Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

March 8, 2012

RHP-12

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Section I. RHP Organization

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Anchoring Entity						
Anchor *Urban Public Hospital*	137999206	17513013627004	Non-State Owned Public	Lubbock County Hospital District dba University Medical Center	Bobbye Hrncirik	602 Indiana Avenue, Lubbock TX 79423 Bobbye.hrncirik@umchealthsystem.com 806-775-8532
IGT Entities *(specify type of government entity, e.g. county, hospital district)*						
IGT Entity *Urban Hospital District*	137999206	17513013627004	Non-State Owned Public	Lubbock County Hospital District dba University Medical Center	Bobbye Hrncirik	602 Indiana Avenue, Lubbock TX 79423 Bobbye.hrncirik@umchealthsystem.com 806-775-8532
IGT Entity *Rural Public Hospital*	130618504	17512270327004	Non-State Owned Public	Terry Memorial Hospital District dba Brownfield Regional Medical Center	Paul Gafford	705 East Felt, Brownfield, TX 79316 paulg@brownfield-rmc.org (806) 637-3551
IGT Entity *CMHC*	127374005	17512943550003	Non-State Owned Public	Central Plains Center	Ron Trusler	2700 Yonkers, Plainview, TX 79072 ron@clplains.org 806-293-2636
IGT Entity *Rural Public Hospital*	133250406	17512283494002	Non-State Owned Public	Childress Regional Medical Center	John Henderson	901 US Hwy 83, Childress, TX 79201 jmh@childresshospital.com 940-937-9178
IGT Entity *City of Amarillo*	pending	17560051397010	Non-State Owned Public	City of Amarillo	Matt Richardson	1000 Martin Road, Amarillo, TX 79107 matt.Richardson@amarillo.gov 806-378-6320

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IGT Entity *City of Lubbock*	135103304	17560005906000	Non-State Owned Public	City of Lubbock	Lee Ann Dumbauld	PO Box 2000, Lubbock, TX 79401 ldumbauld@mail.ci.lubbock.tx.us 806-775-2003
IGT Entity *Rural Public Hospital*	136330107	17524036872002	Non-State Owned Public	Cogdell Memorial Hospital	John H Everett	1700 Cogdell Blvd, Snyder, TX 79549 cmh.jeverett@cogdellhospital.com 325-574-7439
IGT Entity *Rural Public Hospital*	126840107	12009293213000	Private	Collingsworth Hospital District	Candy Powell	1013 15th Street, Wellington, Texas 79095 candypowell@collingsworthgeneral.net 806-447-2521
IGT Entity *Rural Public Hospital*	130826407	17517021626000	Non-State Owned Public	Coon Memorial Hospital and Home	Donny Pettit	1411 Denver Avenue, Dalhart, TX 79022 dlp@dhchd.org 806-244-9270
IGT Entity *Rural Hospital District*	N/A	17522924673555	Non-State Owned Public	Hutchinson County Hospital District	Jock Lee	100 Medical Drive Borger, TX 79007 jockleekt@hotmail.com 806-467-5701
IGT Entity *Rural Hospital District*	094117105	12372971908004	Non-State Owned Public	Hansford County Hospital	Jonathan Bailey	707 S. Roland, Spearman, TX 79081 jonathanbailey@hchd.net 806-659-5858
IGT Entity *CMHC*	127373205	17512419767000	Non-State Owned Public	Helen Farabee Center	Roddy Atkins	1000 Brook Ave, Wichita Falls, TX 76307 atkinsr@helenfarabee.org 940-397-3143
IGT Entity *Rural Public Hospital*	109588703	17560028882005	Non-State Owned Public	Hemphill County Hospital	Christy Francis	1020 South 4th Street, Canadian, TX 79014 Christy@hchdst.org 806-323-6422 ext 260
IGT Entity *Rural Hospital District*	133544006	17560012977004	Non-State Owned Public	Deaf Smith County Hospital District dba Hereford Regional Medical Center	Nathan A. Flood	540 W. 15th St., Hereford, TX 79045 Nathan.flood@dschd.org (806) 364-2141
IGT Entity *Rural Public Hospital*	127313803	17523885154010	Non-State Owned Public	Lamb Healthcare Center	Jo Nell Wischkaemper	1500 S. Sunset, Littlefield, TX jwischkaemper@trhta.net 806-385-6411, ext 204

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
IGT Entity *Rural Public Hospital*	189947801	17560050647002	Non-State Owned Public	Dawson County Hospital District dba Medical Arts Hospital	Melissa Matlock	2200 N. Bryan Ave, Lamesa, Texas 79331 mmatlock@medicalartshospital.org 806-872-5727 x 2035
IGT Entity *Rural Public Hospital*	094180903	17513283543001	Non-State Owned Public	Lynn County Hospital District	Donna Raindl	PO Box 1310, Tahoka, TX 79373 draindl@lchdhealthcare.org 806-998-4533 x 305
IGT Entity *Rural Public Hospital*	094121303	17513626717501	Non-State Owned Public	Gaines County Hospital District dba Memorial Hospital	Betsy Briscoe	209 NW 8th, Seminole, TX 79360 bbriscoe@seminolehospitaldistrict.com 432-758-4898
IGT Entity *Rural Public Hospital*	094129602	17513021521006	Non-State Owned Public	Moore County Hospital District dba Memorial Hospital Moore County	Jeff Turner	224 East 2nd Street Dumas, TX 79029 jturner@mchd.net 806-935-7171 x 1300
IGT Entity *Rural Public Hospital*	130877708	17522904360002	Non-State Owned Public	Muleshoe Area Hospital District dba Muleshoe Area Medical Center	LaJuana Renfro	708 S 1st St, Muleshoe TX 79347 lrenfro@mahdtx.org 806-272-4524 x 103
IGT Entity *Rural Public Hospital*	112704504	17512119037003	Non-State Owned Public	Ochiltree General Hospital	Jeff Barnhart	3101 Garret Drive, Perryton, TX 79070 Jbarnhart@oghtx.com 806-648-7110
IGT Entity *Rural Private Hospital*	N/A	1752383041"Pending"	Non-State Owned Public	Parmer County Hospital District	Gayla Quillin	1307 Cleveland Street, Friona Texas 79035 gquillin@parmermedicalcenter.com 806-250-2754
IGT Entity *Rural Hospital District*	136142011	17560039392501	Non-State Owned Public	Castro County Hospital District dba Plains Memorial Hospital	Linda Rasor, CEO	310 W Halsell St, Dimmitt, TX 79027 linda.rasor@cchdonline.com 806-647-2191
IGT Entity *CMHC*	084897001	17512976915000	Non-State Owned Public	Lubbock MHMR dba Star Care Specialty Health	Cathy Pope	P.O. Box 2828, Lubbock, TX 79408 cpope@starcarelubbock.org 806-766-0221

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
				System		
IGT Entity *Rural Hospital District*	130721710	17560025565000	Non-State Owned Public			
IGT Entity *CMHC*	127378105	17561761218002	Non-State Owned Public	Texas Panhandle Center	Jim Womack	PO Box 3250, Amarillo, TX 79116 jim.womack@txpan.org 806-351-3326
IGT Entity *Physician Practice Associated with a Health Science Center*	084563802	37397397391014	State-Owned	Texas Tech University Health Sciences Center-Amarillo	Richard Jordan, M.D.	1400 S. Coulter, Amarillo, TX 79106 Richard.jordan@ttuhsc.edu 806-354-5401
IGT Entity *Physician Practice Associated with a Health Science Center*	084599202	37397397391007	State-Owned	Texas Tech University Health Sciences Center-Lubbock	Brent D. Magers	3601 4th Street, Lubbock, Texas 79430-6212 brent.magers@ttuhsc.edu 806-743-1830
IGT Entity *CMHC*	130725806	17526061696003	Non-State Owned Public	West Texas Centers	Gail Wells	409 Runnels, Big Spring, Texas 79720 gail.wells@wtcmhmr.org 432-466-1504
IGT Entity *Rural Public Hospital*	126667806	17514249659000	Non-State Owned Public	W.J. Mangold Memorial Hospital	Larry Mullins	P.O. Box 37, Lockney, TX 79241 larrym@mangoldmemorial.org 806-652-3373 Ext. 204
IGT Entity *Rural Public Hospital*	137227806	17560012126009	Non-State Owned Public	Yoakum County Hospital	Chris Ekrem	412 Mustang Drive, Denver City, TX 79323 cekrem@ych.us 806-592-2121
Performing Providers						
Performing Provider *Rural Public Hospital*	130618504	17512270327004	Non-State Owned Public	Terry Memorial Hospital District dba Brownfield Regional Medical Center	Michelle Lewis	705 East Felt, Brownfield, TX 79316 smlewis2012@gmail.com (806) 637-3551

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Performing Provider *CMHC*	127374005	17512943550003	Non-State Owned Public	Central Plains Center	Ron Trusler	2700 Yonkers, Plainview, TX 79072 ron@clplains.org 806-293-2636
Performing Provider *Rural Public Hospital*	133250406	17512283494002	Non-State Owned Public	Childress Regional Medical Center	John Henderson	901 US Hwy 83, Childress, TX 79201 jmh@childresshospital.com 940-937-9178
Performing Provider *Local Health Department*	pending	17560051397010	Non-State Owned Public	City of Amarillo Dept Public Health	Matt Richardson	1000 Martin Road, Amarillo, TX 79107 matt.Richardson@amarillo.gov 806-378-6320
Performing Provider *Local Health Department*	135103304	17560005906000	Non-State owned Public	City of Lubbock Health Department	Becky Brawley	1902 Texas Avenue, Lubbock, TX 79415 bbrawley@mylubbock.us 806-775-2941
Performing Provider *Rural Public Hospital*	136330107	17524036872002	Non-State Owned Public	Cogdell Memorial Hospital	John H Everett	1700 Cogdell Blvd, Snyder, TX 79549 cmh.jeverett@cogdellhospital.com 325-574-7439
Performing Provider *Rural Private Hospital*	126840107	12009293213000	Private	Preferred Leasing, Inc. dba Collingsworth General Hospital	Candy Powell	1013 15th Street, Wellington, Texas 79095 candypowell@collingsworthgeneral.net 806-447-2521
Performing Provider *Rural Public Hospital*	130826407	17517021626000	Non-State Owned Public	Coon Memorial Hospital and Home	Donny Pettit	1411 Denver Avenue, Dalhart, TX 79022 dlp@dhchd.org 806-244-9270
Performing Provider *Urban Children's Hospital*	127319504	17524289117002	Private	Covenant Children's Hospital	Chris Dougherty	3615 19th Street, Lubbock, Texas 79410 doughertyc1@covhs.org 806-725-0000
Performing Provider *Urban Private Hospital*	139461107	17527655660501	Private	Covenant Medical Center	Steve Beck	3615 19th Street, Lubbock, TX 79410 becks2@covhs.org 806-725-0522
Performing Provider *Rural Public Hospital*	197063401	12603289294001	Private	Golden Plains Community Hospital	Dennis Jack	100 Medical Drive, Borger TX 79007 ceogpch@goldenplains.org 806-467-5702
Performing Provider *CMHC*	127373205	17512419767000	Non-State Owned Public	Helen Farabee Center	Roddy Atkins	1000 Brook Ave, Wichita Falls, TX 76307 atkinsr@helenfarabee.org 940-397-3143

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Performing Provider *Urban Private Hospital*	281514401	12640210162000	Private	Lubbock Heritage Hospital LLC, dba Grace Medical Center	Dana Rains	2415 50th Street, Lubbock, TX 79412 drains@gracehealthsystem.com 806-773-2532
Performing Provider *Rural Public Hospital*	094117105	12372971908004	Non-State Owned Public	Hansford County Hospital	Jonathan Bailey	707 S. Roland Spearman, TX 79081 jonathanbailey@hchd.net 806-659-5858
Performing Provider *Rural Public Hospital*	109588703	17560028882005	Non-State Owned Public	Hemphill County Hospital	Christy Francis	1020 South 4th Street, Canadian, TX 79014 Christy@hchdst.org 806-323-6422 ext 260
Performing Provider *Rural Public Hospital*	133544006	17560012977004	Non-State Owned Public	Deaf Smith County Hospital District dba Hereford Regional Medical Center	Nathan A. Flood	540 W. 15th St., Hereford, TX 79045 Nathan.flood@dschd.org 806-364-2141
Performing Provider *Rural Public Hospital*	127313803	17523885154010	Non-State Owned Public	Lamb Healthcare Center	Jo Nell Wischkaemper	1500 S. Sunset, Littlefield, TX jwischkaemper@trhta.net 806-385-6411, ext 204
Performing Provider *Rural Public Hospital*	094180903	17513283543001	Non-State Owned Public	Lynn County Hospital District	Donna Raindl	PO Box 1310 Tahoka, TX 79373 draindl@lchdhealthcare.org 806-998-4533 x 305
Performing Provider *Rural Public Hospital*	189947801	17560050647002	Non-State Owned Public	Dawson County Hospital District dba Medical Arts Hospital	Melissa Matlock	2200 N. Bryan Ave, Lamesa, Texas 79331 mmatlock@medicalartshospital.org 806-872-5727 x 2035
Performing Provider *Rural Public Hospital*	094121303	17513626717501	Non-State Owned Public	Gaines County Hospital District dba Memorial Hospital	Betsy Briscoe	209 NW 8th, Seminole, TX 79360 bbriscoe@seminolehospitaldistrict.com 432-758-4898
Performing Provider *Rural Public Hospital*	094129602	17513021521006	Non-State Owned Public	Moore County Hospital District dba Memorial Hospital Moore County	Jeff Turner	224 East 2nd Street Dumas, TX 79029 jturner@mchd.net 806-935-7171 x 1300

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Performing Provider *Rural Public Hospital*	130877708	17522904360002	Non-State Owned Public	Muleshoe Area Hospital District dba Muleshoe Area Medical Center	LaJuana Renfro	708 S 1st St Muleshoe TX 79347 lrenfro@mahdtx.org 806-272-4524 x 103
Performing Provider *Rural Public Hospital*	112704504	17512119037003	Non-State Owned Public	Ochiltree General Hospital	Jeff Barnhart	3101 Garret Drive, Perryton, TX 79070 Jbarnhart@oghtx.com 806-648-7110
Performing Provider *Rural Private Hospital*	178848102	14551256879000	Private	Prime Healthcare Pampa Regional Medical Center	Brad Morse	One Medical Plaza, Pampa, TX 70965 bradmorse@prmc.primehealthcare.com 806-663-5500
Performing Provider *Rural Private Hospital*	137343308	17507033375001	Private	Parmer County Community Hospital	Gayla Quillin	1307 Cleveland Street, Friona, TX 79035 gquillin@parmermedicalcenter.com 806-250-2754
Performing Provider *Rural Public Hospital*	136142011	17560039392501	Non-State Owned Public	Castro County Hospital District dba Plains Memorial Hospital	Linda Rasor, CEO	310 W Halsell St, Dimmitt, TX 79027 linda.rasor@cchdonline.com 806-647-2191
Performing Provider Physician Practice NOT Associated with a Health Science Center	079877902	17526464775004		Physician Network Services	Paul Acreman	5219 Citybank Pkwy Ste160, Lubbock, TX 79407 Paul.acreman@umchealthsystem.com 806-761-0333
Performing Provider *CMHC*	084897001	17512976915000	Non-State Owned Public	Star Care Specialty Health System	Cathy Pope	P.O. Box 2828, Lubbock, TX 79408 cpope@starcarelubbock.org 806-766-0221
Performing Provider *Psychiatric Hospital*	136492909	17512976915000	Non-State Owned Public	Sunrise Canyon Hospital	Cathy Pope	P.O. Box 2828, Lubbock, TX 79408 cpope@starcarelubbock.org 806-766-0221
Performing Provider *CMHC*	127378105	17561761218002	Non-State Owned Public	Texas Panhandle Centers	Jim Womack	PO Box 3250, Amarillo, TX 79116 jim.womack@txpan.org 806-351-3326
Performing Provider *Physician Practice*	084563802	37397397391014	State-Owned	Texas Tech University Health	Richard Jordan, M.D.	1400 S. Coulter, Amarillo, TX 79106 Richard.jordan@ttuhsc.edu

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Associated with a Health Science Center				Sciences Center-Amarillo		806-354-5401
Performing Provider *Physician Practice Associated with a Health Science Center*	084599202	37397397391007	State-Owned	Texas Tech University Health Sciences Center-Lubbock	Brent D. Magers	3601 4th Street Lubbock, Texas 79430-6212 brent.magers@ttuhsc.edu 806-743-1830
Performing Provider *CMHC*	130725806	17526061696003	Non-State Owned Public	West Texas Centers	Gail Wells	409 Runnels, Big Spring, Texas 79720 gail.wells@wtcmhmr.org 432-466-1504
Performing Provider *Urban Public Hospital*	137999206	17513013627004	Non-State Owned Public	Lubbock County Hospital District dba University Medical Center	Bobbye Hrncirik	602 Indiana Avenue, Lubbock TX 79423 Bobbye.hrncirik@umchealthsystem.com 806-775-8532
Performing Provider *Rural Public Hospital*	126667806	17514249659000	Non-State Owned Public	W.J. Mangold Memorial Hospital	Larry Mullins	P.O. Box 37, Lockney, TX 79241 larrym@mangoldmemorial.org 806-652-3373 Ext. 204
Performing Provider *Rural Public Hospital*	137227806	17560012126009	Non-State Owned Public	Yoakum County Hospital	Chris Ekrem	412 Mustang Drive, Denver City, TX 79323 cekrem@ych.us 806-592-2121
UC-only Hospitals						
UC-Only *Urban Private Hospital*	133457505	17508006693004	Private	Baptist St. Anthony's Health System - Baptist Campus	Brian Walton	1600 Wallace Blvd. Amarillo TX 79106 Brian.Walton@bsahs.org 806-212-8170
UC-Only *Rural Public Hospital*	094152803	17512558465000	Non-State Owned Public	Cochran Memorial Hospital	Larry Turney	201 East Grant, Morton, TX 79346 lturney@cochranmemorial.com 806-266-5565
UC-Only *Rural Private Hospital*	133258705	17522463482000	Private	Covenant Hospital Levelland	Jerry Osburn	1900 S College Ave, Levelland, TX 79336" josburn@covhs.org (806)-894-4963

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
UC-Only *Rural Private Hospital*	127263503	17524260100000	Private	Covenant Hospital Plainview	Alan King	2601 Dimmitt Road, Plainview, Texas 79027" alan.king@stjoe.org 806-296-5531
UC-Only *Rural Private Hospital*	094141105	17507112765000	Private	Crosbyton Clinic Hospital	Debra Miller	710 West Main, Crosbyton, TX 79322 debra.Miller@crosbytonclinichospital.com 806-675-8701
UC-Only *Rural Public Hospital*	121787905	17511886750000	Non-State Owned Public	Parkview Hospital	Monica Kidd	Box 1030, 901 S Sweetwater St, Wheeler Tx 79096 monicak@parkviewhosp.org 806-826-5581
UC-Only *Urban Private Hospital*	137245009	12322389763501	Private	Northwest	Carlos Zaffirini	401 W 15th St, Suite 840, Austin, TX 78701 carlos@ahcv.com 512-322-9413
UC-Only *Rural Public Hospital*	130721710	17560025565000	Non-State Owned Public	Swisher Memorial Hospital	Pam Clark	539 S.E. 2nd Street, Tulia, TX 79088 rbarnard@swisherhospital.com 806-995-3581
Other Stakeholders						
County Medical Society				Lubbock, Crosby, Garza County Medical Society	Dr. Mike Ragain	Mike.ragain@umchealthsystem.com 806-775-
County Medical Society				Potter-Randall County Medical Society	Dr. Paul Proffer	prcms@suddenlinkmail.com 806-355-6854
County Judge				Cottle County	Judge Gregory	cottlejdg@yahoo.com 806-492-3613
County Auditor				Gaines/Garza County	Rick Dollehen	806-872-5631

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Office of Representative				Charles Perry Office	Robyn Tepper	Robyn.tepper@house.state.tx.us 806-783-9934
FQHC				Community Health Center Lubbock	Mike Sullivan	(806) 765-2611 ext. 1029 msullivan@chcl.tachc.org
FQHC				Combest Center	Linda McMurry	Linda.mcmurry@ttuhsc.edu 806-743-9393
State Health Services				Texas Department of State Health Services	Peter Pendergrass	peter.pendergrass@dshs.state.tx.us 806-744-3577
Office of Representative				John Frullo Office	Kimberly Lile	Kimberly.lile@house.state.tx.us 806-763-2366
Coalition of Health Services				Coalition of Health Services	Carolyn Witherspoon	carolyn.witherspoon@covhs.net 806-337-1700
Area Foundation				Amarillo Area Foundation	Angela Lust	angela@aaf-hf.org 806-376-4521
Planning Commission				Panhandle Regional Planning Commission	Gary Pitner	gpitner@theprpc.org 806-372-3381
Area Health Education				Panhandle AHEC	Tommy Sweat	tsweat@mailowtamu.edu 806-651-3481
Texas Silver Haired Legislature				Texas Silver Haired Legislature	Alan Abraham (Nancy)	Alan.nancy@sbcglobal.net

Section II. Executive Overview of RHP Plan

The overall vision for the Region 12 RHP is to assure residents receive high-quality, patient-centered care, in a cost effective manner that focuses on coordinated care delivery and improved health outcomes, with a particular focus on the Medicaid and uninsured residents, while containing cost growth. The vision is to fulfill as many of the community needs identified in the area as possible focusing on those identified as urgent and critical needs. These include improving quality and performance, increasing access to care, and increasing prevention and early detection activities.

RHP 12 is comprised of 47 counties in the Texas panhandle. The area is mostly rural and frontier, which means that there are less than 12 people per square mile. There are two urban areas, which are the Lubbock area (Lubbock County) and the Amarillo area (Potter County and Randall County).

According to the Behavioral Risk Factor Surveillance System (BRFSS) (2010), 59.8% of residents had employer-based health insurance; 19.2% had Medicare; 4.0% had Medicaid; 2.7% had Veteran's Administration or Military Insurance; 0.6% had coverage through JO Wyatt or a District Clinic; and 0.3% had other coverage. 13.4% of residents were uninsured.

Because of the remoteness of the rural areas of the region, which comprises the bulk of RHP-12, there are major health care provider shortages, multiple counties with no acute care hospitals, and significant transportation issues to access primary care services especially after normal business hours. In addition, the region has a large minority population, limited English proficient population, and the educational levels of adults in the region are significantly below state and national levels.

A survey of independent health related data as well as a health needs assessment completed by the West Texas Area Health Education Center (AHEC) in response to this initiative was conducted. The outcome of the analysis not only identified challenges for the region, but also ranked the issues in three tiers according to the availability of evidence documenting the need. Tier one included the two most pressing needs in RHP 12: 1) a severe lack of primary care access including provider shortages, financial barriers, wait times, and length of time to get an appointment; and 2) a lack of mental health services including lack of available appointments, insurance coverage, and emergency room usage for mental health issues. The second tier identified the priority issues as: 1) uninsured and underinsured; 2) high incidence of obesity, diabetes, and heart disease; 3) need for specialty care; and 4) need for cancer screenings; and 5) insufficient maternal and prenatal care.

From the patient perspective, the relatively high level of employer-based insurance is not reflective of the ability of area residents to actually access services. The remoteness of the area prevents patients from accessing care, which is often only available after a one hour drive across desolate roads. The individuals who are the target of this initiative, Medicaid consumers and uninsured individuals, often do not even have reliable transportation to make this journey safely, if at all. Therefore, a need exists to increase the availability of care in those remote areas. This will be accomplished through expanded primary care services, utilization of telemedicine, and integrated behavioral health services.

According to the health needs assessment completed for this initiative, in Amarillo 21.2% needed to see a doctor, but could not due to the cost. In the rural areas, when asked if anyone in their household was currently having difficulty accessing medical care; cost of services was a barrier for 19% of respondents. Of those that have private insurance, 20% reported that their deductible was “too expensive” and 17% said their insurance coverage was inadequate to their healthcare needs. The high cost of prescription drugs was a barrier to 22% of the persons queried. The other most significant barriers identified in the needs assessment included long wait times at provider offices (23%) ; an inability to get an appointment (16%); and lack of transportation (6%).

Finally, Federally Qualified Health Centers (FQHC) are typically the safety net providers across Texas. Previously there was an initiative in Texas, the FQHC Incubator Program, which sought to expand the number of FQHCs across the state. However, these program sunsets so there are no other concerted efforts by the Department of State Health Services to expand access to primary care in underserved areas through FQHCs.

This will be accomplished through the following goals and objectives:

- Expand primary care capacity and quality
  - Decrease address non-emergent emergency room usage
  - Increase facilities for primary care
  - Increase patient centered medical home capacity
  - Increase prevalence of chronic disease management among providers
  - Improve ability to recruit providers
  - Increase access to mental health services

- Enhance performance improvement capacity
  - Address patient satisfaction issues

    - Improving patient and disease tracking capacity
    - Reduce potentially preventable re-admissions
    - Utilize non-traditional service methodology such as telemedicine

- Implement disease prevention activities
    - Implement health promotion activities
    - Increase availability of prevention and early detection services

- *Complete the summary of Categories 1-2 projects table below for all projects in the RHP Plan. The table is based on projects listed in Section V.*

Summary of Categories 1-2 Projects

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Category 1: Infrastructure Development			
130618504.1.1, Expand Primary Care Capacity Brownfield Regional Medical Center 130618504	1.1.2 - Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate	$1,993,278
127374005.1.1 – **"PASS 2"** Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services Central Plains Center 127374005	1.11.2 - Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.	TBD	$580,008
133250406.1.1, Enhance Urgent Medical Advice Childress Regional Medical Center 133250406	1.6.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.	IT-3.2 Congestive Heart Failure 30 day readmission rate	$921,700
135103304.1.1, Increase, Expand, and Enhance Dental Services City of Lubbock Public Health Department 135103304	1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.	IT-7.7 Urgent Dental Needs in Older Adults	$8,561,029

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
135103304.1.2 **"PASS 2"** Increase, Expand, and Enhance Oral Health Services City of Lubbock Public Health Department, 135103304	1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.	IT-7.7 Urgent Dental Needs for Adults	$1,222,918
136330107.1.1, Expand Primary Care Capacity Cogdell Memorial Hospital 136330107	1.1.2 - Expand existing primary care capacity.	IT-1.1 Third next available appointment	$2,431,794
136330107.1.3 "PASS 3b" Enhance Performance Improvement and Reporting Capacity Cogdell Memorial Hospital 136330107	1.10.1 - Enhance improvement capacity within people	IT-2.1 Congestive Heart Failure Admission Rate	$1,755,509
130826407.1.1, Expand Primary Care Capacity Coon Memorial Hospital 130826407	1.1.2 - Expand existing primary care capacity.	IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$1,669,586
130826407.1.3 "PASS 3b" 1.8 - Increase, Expand, and Enhance Oral Health Services Coon Memorial Hospital and Home 130826407	1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.	3.IT-7.2 Cavities: Percentage of Children With Untreated Dental Caries (Healthy People 2020)	$1,011,096
197063401.1.1, Implement a Chronic Disease Management Registry Golden Plains Community Hospital 197063401	1.3.1 - Implement/enhance and use chronic disease management registry functionalities.	IT-10.1 Quality of Life	$2,092,285

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
197063401.1.2, Expand Primary Care Capacity Golden Plains Community Hospital 197063401	1.1.2 - Expand existing primary care capacity.	IT-1.7 Controlling High Blood Pressure	$3,975,342
197063401.1.3, Expand Primary Care Capacity Golden Plains Community Hospital 197063401	1.1.2 - Expand existing primary care capacity.	IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$3,556,885
281514401.1.1, Expand Primary Care Capacity. Lubbock Heritage Hospital, LLC, dba Grace Medical Center 281514401	1.1.2 - Expand existing primary care capacity.	IT-9.2 ED appropriate utilization	$2,348,845
094117105.1.1, Expand Specialty Care Capacity Hansford County Hospital 094117105	1.9.2 - Improve access to specialty care	IT-6.1 Percent improvement over baseline of patient satisfaction scores	$182,699
094117105.1.3 "PASS 3b" Expand Primary Care Capacity Hansford County Hospital 094117105	1.1.2 - Expand existing primary care capacity	IT-6.1 Percent improvement over baseline of patient satisfaction scores	$851,947
127373205.1.1, Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care Helen Farabee Center 127373205	1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas.	IT-10.1 Quality of Life.	$434,617

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
1273733205.1.2, Expand Specialty Care Capacity Helen Farabee Center 1273733205	1.9.2 - Improve access to specialty care.	IT-10.1 Quality of Life.	$49,025
133544006.1.1, Expand Primary Care Capacity Deaf Smith County Hospital District dba Hereford Regional Medical Center 133544006	1.1.2 - Expand existing primary care capacity.	IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$2,091,731
13354406.1.2, **"PASS 2"** Enhance service availability of appropriate levels of behavioral health care Deaf Smith County Hospital District dba Hereford Regional Medical Center 133544006	1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas	IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$307,880
127313803.1.1, Expand Primary Care Capacity Lamb Healthcare Center 127313803	1.1.2 - Expand existing primary care capacity.	IT-2.1 Congestive Heart Failure Admission rate.	$1,494,536
189947801.1.1, Introduce, Expand, or Enhance Telemedicine/Telehealth Dawson County Hospital District dba Medical Arts Hospital 189947801	1.7.1 - Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.	IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$932,743
189947801.1.2, Introduce, Expand, or Enhance Telemedicine/Telehealth Dawson County Hospital District dba Medical Arts Hospital 189947801	1.7.2 - Implement remote patient monitoring programs for diagnosis and/or management of care.	IT-3.2 Congestive Heart Failure 30 day readmission rate.	$603,539

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
189947801.1.5 "PASS 3b" Expand Specialty Care Capacity Dawson County Hospital District dba Medical Arts Hospital 189947801	1.9.2 - Improve access to specialty care	IT-6.1 Percent improvement over baseline of patient satisfaction scores	$1,045,738
189947801.1.4, **"PASS 3"** Expand Primary Care Capacity Dawson County Hospital District dba Medical Arts Hospital 189947801	1.1.2 - Expand existing primary care capacity	IT-9.2Appropriate ED Utilization	$279,319
094129602.1.1, Expand Primary Care Capacity Moore County Hospital District dba Memorial Hospital, Moore Co 094129602	1.1.1 - Establish more primary care clinics.	IT-1.7 Controlling High Blood Pressure.	$923,405
094129602.1.3, "PASS 3b" Expand Specialty Care Capacity Moore County Hospital District dba Memorial Hospital, Moore Co 094129602	1.9.2 - Improve access to specialty care	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$957,991
094121303.1.1 Expand Primary Care Capacity Memorial Hospital, Gaines Co 094121303	1.1.2 - Expand existing primary care capacity.	IT-1.11 Diabetes Care: BP Control	$1,356,188
130877708.1.1, Expand Primary Care Capacity Muleshoe Area Medical Center, 130877708	1.1.1 – Establish more primary care clinics.	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$182,699

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
112704504.1.1, Expand Primary Care Capacity Ochiltree General Hospital 112704504	1.1.2 - Expand existing primary care capacity.	IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$952,590
178848102.1.1, Expand Primary Care Capacity Pampa Regional Medical Center 178848102	1.1.2 - Expand existing primary care capacity.	IT-1.7 Controlling High Blood Pressure.	$3,009,406
079877902.1.1, **"PASS 2"** Expand Primary Care Capacity Physician Network Services 079877902	1.1.1 - Establish more primary care clinics	IT-1.7 Controlling High blood pressure	$5,383,937
084897001.1.1, Development of behavioral health crisis stabilization services as alternatives to hospitalization StarCare Specialty Health System 084897001	1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.	IT-9.2 ED Appropriate Utilization.	$11,810,102
084897001.1.2, **"PASS 2"** Development of behavioral health crisis stabilization services as alternatives to hospitalization StarCare Specialty Health System 084897001	1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	IT-9.2 ED Appropriate Utilization	$1,710,067
127378105.1.1, Development of behavioral health crisis stabilization services as alternatives to hospitalization Texas Panhandle Centers 127378105	1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.	IT-10.1 Quality of Life	$4,116,727

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
084563802.1.1, Expand Specialty Care Capacity Texas Tech University Health Sciences Center-Amarillo 084563802	1.9.1 - Expand high impact specialty care capacity in most impacted medical specialties	IT-9.4 Other Outcome Improvement Target.	$3,669,142
084563802.1.2, Increase Training of Primary Care Workforce Texas Tech University Health Sciences Center-Amarillo 084563802	1.2.4 - Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)	TBD	$3,261,459
084563802.1.3, **"PASS 2"** Expand Specialty Care Capacity Texas Tech University Health Sciences Center-Amarillo 084563802	1.9.2 - Improve access to specialty care	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$3,257,916
084563802.1.4, **"PASS 3"** Introduce, Expand, or Enhance Telemedicine/Telehealth Texas Tech University Health Sciences Center-Amarillo 084563802	1.7.5 - Use telehealth services to provide medical education and specialized training for targeted professionals in remote locations.	IT-8.9 Other outcome improvement target	$303,040
084599202.1.1, Increase Training of Primary Care Workforce Texas Tech University Health Sciences Center-Lubbock 084599202	1.2.4 - Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)	TBD	$4,107,023
084599202.1.2, Enhance Urgent Medical Advice Texas Tech University Health Sciences Center-Lubbock, 084599202	1.6.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.	TBD	$4,363,712

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
084599202.1.3, Expand Specialty Care Capacity, Texas Tech University Health Sciences Center-Lubbock, 084599202	1.9.1 - Expand high impact specialty care capacity in most impacted medical specialties.	TBD	$3,850,334
137999206.1.1, Implement a Chronic Disease Management Registry, University Medical Center, 137999206	1.3.1 - Implement/enhance and use chronic disease management registry functionalities	IT-3.1 All Cause 30 day Readmission Rate	$10,450,337
137999206.1.2, Enhance Urgent Medical Advice, University Medical Center, 137999206	1.6.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.	IT-9.2 ED Appropriate utilization	$9,927,821
137999206.1.3, Enhance Performance Improvement and Reporting Capacity, University Medical Center, 137999206	1.10.1 - Enhance improvement capacity within people	IT-4.4 Surgical Site Infection (SSI) rates	$8,882,786
130725806.1.1, Implement technology-assisted services to support, coordinate, or deliver behavioral health services West Texas Centers 130725806	1.11.3 – “Other” Project Option	IT-6.2 Other Outcome Improvement Target.	$1,271,896

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
130725806.1.2, **"PASS 2"** Development of behavioral health crisis stabilization services as alternatives to hospitalization West Texas Centers 130725806	1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	IT-6.2 Other Improvement Target	$449,304
137227806.1.2 "PASS 3b" Introduce, Expand, or Enhance Telemedicine/Telehealth Yoakum County Hospital 137227806	1.7.1 - Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$1,032,425
Category 2: Program Innovation and Redesign			
130618504.2.2, "PASS 3b" Establish/Expand a Patient Care Navigation Program Brownfield Regional Medical Center 130618504	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (eg: patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)	IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate	$964,171
127374005.2.1, Integrate Primary and Behavioral Health Care Services Central Plains Center 127374005	2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	TBD	$2,386,438

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
127374005.2.2, Recruit, train and support consumers of mental health services to provide peer support services Central Plains Center 127374005	2.18.1 - Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.	TBD	$1,670,507
133250406.2.1 Enhance/Expand Medical Homes Childress Regional Medical Center 133250406	2.1.3 - Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative	IT-6.1 Percent Improvement over Patient Satisfaction Scores	$972,907
133250406.2.3 "PASS 3b" Use of Palliative Care Programs Childress Regional Medical Center 133250406	2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs	IT-13.2 Proportion with more than one emergency room visit in the last days of life	$1,922,828
Pending.2.1 Implement Evidence-based Disease Prevention Programs City of Amarillo Department of Public Health TPI pending	2.7.6 – "Other" project option	IT-2.10 Flu and pneumonia Admission Rate	$8,663,251

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Pending.2.2 **"PASS 2"** Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.). City of Amarillo Department of Public Health TPI Pending	2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	IT-9.1 Decrease in Mental Health admissions and readmissions to criminal justice settings such as jail or prison	$1,238,557
136330107.2.1 Redesign primary care Cogdell Memorial Hospital 136330107	2.3.1 - Redesign primary care in order to achieve improvements in efficiency, access, continuity of care, and patient experience	IT-12.1 Breast Cancer Screening; IT-12.3 Colorectal Cancer Screening; IT-12.4 Pneumonia vaccination status for older adults.	$1,178,096
126840107.2.1, Expand Chronic Care Management Models, Preferred Leasing dba Collingsworth General Hospital, 126840107	2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.	IT-2.1 Congestive Heart Failure Admission Rate	$139,692
126840107.2.3, "PASS 3b" Redesign to Improve Patient Experience Preferred Leasing dba Collingsworth General Hospital 126840107	2.4.3 - Project Option: Increased patient satisfaction	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$204,307
127319504.2.1 Establish/Expand a Patient Care Navigation Program Covenant Children's Hospital 127319504	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and	IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits	$10,169,711

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	others)		
139461107.2.1, Apply Process Improvement Methodology to Improve Quality/Efficiency, Covenant Medical Center, 139461107	2.8.11 - Project Option: Sepsis	IT-4.8 Sepsis Mortality	$13,491,617
139461107.2.2, Establish/Expand a Patient Care Navigation Program, Covenant Medical Center, 139461107	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (eg, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)	IT-3.12 Other Readmission Rate	$11,805,165
139461107.2.3, Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders, Covenant Medical Center, 139461107	2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders.	IT-10.1 Quality of Life.	$15,178,069

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
139461107.2.4, Use of Palliative Care Programs, Covenant Medical Center, 139461107	2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs	IT-13.1 Pain Assessment IT-13.2 Treatment Preferences IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss.	$10,118,712
197063401.2.1, Apply Process Improvement Methodology to Improve Quality/Efficiency, Golden Plains Community Hospital, 197063401	2.8.6 - Reduce Inappropriate ED Use.	IT-9.2 ED appropriate utilization	$3,138,428
197063401.2.2, **"PASS 2"** Enhance/Expand Medical Homes Golden Plains Community Hospital 197063401	2.1.3 - Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative	IT-9.2 ED Appropriate Utilization	$1,873,395
109588703.2.1, Establish/Expand a Patient Care Navigation Program Hemphill County Hospital 109588703	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (eg, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and	IT-6.1 Percent Improvement over baseline of Patient Satisfaction Score.	$80,688

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	others)		
133544006.2.2 "PASS 2" Redesign to Improve Patient Experience Deaf Smith County Hospital District dba Hereford Regional Medical Center 133544006	2.4.1 - Implement processes to measure and improve patient experience	IT-6.1 Percent Improvement over baseline of Patient Satisfaction Score.	$1,643,169
094180903.2.1, Establish/Expand a Patient Care Navigation Program Lynn County Hospital District 094180903	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (eg, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)	IT-9.2 ED Appropriate Utilization.	$189,977
094121303.2.1, **"PASS 2"** Conduct Medication Management Memorial Hospital, Gaines Co 094121303	2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors	IT-1.7 Controlling High Blood Pressure	$194,165
130877708.2.1, Implement Evidence-based Health Promotion Programs, Muleshoe Area Medical Center, 130877708	2.6.2 - Establish self-management programs and wellness using evidence-based designs.	IT-10.1 Quality of Life	$445,608
112704504.2.1, **"PASS 2"** Redesign to Improve Patient Experience, Ochiltree General Hospital, 112704504	2.4.1 - Implement processes to measure and improve patient experience	IT-6.1 Percent Improvement over baseline of Patient Satisfaction Score	$136,382

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
137343308.2.1, Expand Chronic Care Management Models Parmer County Community Hospital, Inc. 137343308	2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.	IT-2.1 Congestive Heart Failure Admission rate	$361,892
137343308.2.3 "PASS 3b" Redesign to Improve Patient Experience, Parmer County Community Hospital, Inc., 137343308	2.4.3 - Project Option: Increased patient satisfaction	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$236,173
136142011.2.1, Establish/Expand a Patient Care Navigation Program, Plains Memorial Hospital, 136142011	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care, (eg, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)	IT-9.2 ED appropriate utilization.	$515,963
136492909.2.1, **"PASS 2"** Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting Sunrise Canyon Hospital 136492909	2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	IT-9.2 ED Appropriate Utilization	$6,729,302

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
127378105.2.1, Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting Texas Panhandle Centers 127378105	2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	IT-10.1 Quality of Life	$5,881,040
127378105.2.2, Integrate Primary and Behavioral Health Care Services, Texas Panhandle Centers, 127378105	2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	IT-10.1 Quality of Life	$4,998,884
127378105.2.3, **"PASS 2"** Recruit, train and support consumers of mental health services to provide peer support services, Texas Panhandle Centers, 127378105	2.18.1 - Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.	IT-10.1 Quality of Life	$2,048,986
084563802.2.1, Enhance/Expand Medical Homes, Texas Tech University Health Sciences Center-Amarillo, 084563802	2.1.1 - Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.	IT-6.1 Percent Improvement Over Baseline Of Patient Satisfaction Scores	$3,669,142

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
084563802.2.2, Implement Evidence-based Health Promotion Programs, Texas Tech University Health Sciences Center-Amarillo, 084563802	2.6.4 - Implement other evidence-based project to implement health promotion programs in an innovative manner not described in the project options above	IT-3.9 Chronic Obstructive Pulmonary Disease 30 Day Readmission Rate	$3,261,459
084599202.2.1, Implement Evidence-based Disease Prevention Programs, Texas Tech University Health Sciences Center-Lubbock 084599202	2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)	TBD	$4,107,023
084599202.2.2, Establish/Expand a Patient Care Navigation Program, Texas Tech University Health Sciences Center-Lubbock, 084599202	2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (eg, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)	TBD	$4,363,712
084599202.2.3, **"PASS 2"** Apply Process Improvement Methodology to Improve Quality/Efficiency, Texas Tech University Health Sciences Center-Lubbock, 084599202	2.8.1 - Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.	TBD	$3,610,649

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
137999206.2.1, Expand Chronic Care Management Models, University Medical Center, 137999206	2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.	IT-1.12 Diabetes Care: Retinal eye exam. IT-1.13 Diabetes care Foot exam. IT-1.14 Diabetes care: Microalbumin/Nephropathy	$9,927,821
137999206.2.2, Redesign Primary Care, University Medical Center, 137999206	2.3.2 - "Other" project option: Implement other evidence-based project to redesign primary care in an innovative manner not described in the project options above	IT-3.1 All Cause 30 day Readmission Rate	$9,927,821
137999206.2.3, Conduct Medication Management, University Medical Center, 137999206	2.11.2 - Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.	IT-3.3 Diabetes 30 day readmission rate.	$9,927,821
137999206.2.4, **"PASS 2"** Use of Palliative Care Programs, University Medical Center, 137999206	2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs	IT-13.3 Proportion with more than one emergency room visit in the last days of life x	$8,467,517

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP) for DYs 2-5
130725806.2.1, Integrate Primary and Behavioral Health Care Services, West Texas Centers 130725806	2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	IT-6.2 Other Outcome Improvement Target	$1,707,680
137227806.2.1, Implement Evidence-based Health Promotion Programs, Yoakum County Hospital, 137227806	2.6.2 - Establish self-management programs and wellness using evidence-based designs.	IT 3.3 Diabetes 30 day readmission rate.	$1,443,289

Section III. Community Needs Assessment

The data used for this section was collected and analyzed under the direction of the West Texas AHEC. The first step of the project consisted of focus group meetings in 11 counties within RHP-12 Rural. Focus groups were conducted to gain a better understanding of community health needs and available resources. Subjects were recruited by West Texas AHEC staff in collaboration with the community champion. Focus group participants consisted of local government officials, local health care providers, and other community members who had a stake in public health. The focus groups were conducted by a moderator from the Earl Research Survey Lab.

The next step of the project consisted of telephone surveys that were conducted by the Earl Research Survey Lab. The goal was to complete 100 random-digit telephone surveys, 3 per each county, from residents living in RHP-12 Rural owning a land-line. In RHP-12 Rural 1023 telephone surveys were completed with a response rate of 11.29% and a cooperation rate of 40.67%. Surveys were conducted in Spanish and English. The survey instrument contained questions regarding basic demographics, health care access and various health and behavior indicators.

The RHP 12 Urban area needs assessment was based on a similar study completed by Covenant Hospital.

Behavioral Risk Factor Surveillance Survey (BRFSS), Census, and other health and demographic data was obtained from the Texas Department of State Health Services (DSHS).

- *Demographics (e.g. race/ethnicity, gender, language, age, income, education, employment, large employers)*

RHP Region 12 is comprised of both urban and rural areas. The RHP-12 Urban region consists of 3 counties: Lubbock, Potter and Randall counties. According to the 2010 Census, the urban region consists of 2,745 square miles with a population density of 189.66 residents per square mile. The rural portion of the region consists of 42,793 square miles with a population density of 8.65 residents per square mile. Population densities of less than 7 people per square mile are considered frontier. The RHP-12 region is larger than the State of Ohio and larger than 17 other states in the union.

According to the county-based population estimates from the United States Census Bureau, RHP-12 Rural changed in population from 369,552 in April, 2000 to an estimated 370,191 in April, 2010 by 639 residents. This reflects an increase of 0.2% in population. During the same period, the RHP-12 Urban area changed in population from 460,486 in April, 2000 to an estimated 520,629 in April, 2010 by 60,143 residents. This reflects an increase of 13.1 percent in population. During the same time period, the state's population changed by 4,293,741 residents from 20,851,820 to an estimated

25,145,561 persons representing a comparative change of 20.6%. The RHP-12 region's race/ethnic distribution in 2010 is estimated by the Census Bureau to be:

Race/ Ethnicity	RHP-12 Rural Percent	RHP-12 Urban Percent
White	79.3	88.5
Black	3.4	14.29
Other	15.2	18.15
Hispanic°	42.8	32.9
Total Population	44.1	55.9

° Hispanic count includes White, Black and other representation when reported.

RHP-12 Race/Ethnicity	Number	Percentage
Non-Hispanic/Latino		
White	506,209	56.8
Black	46,324	5.2
American Indian or Alaskan Native	3,839	0.4
Asian/Native Hawaiian/Other Pacific Islander	14,612	1.6
Other	10,134	1.1
Hispanic/Latino	309,702	34.8
Total	890,820	100.0

The gender distribution of an area can provide additional insight into the RHP-12 rural region's overall distribution in the population by male and female. Of RHP-12 rural population, males comprised 51.5% of the population and females comprised 48.5%. Of the RHP-12 Urban area's population, 258,442 were male which represents 49.6% and 262,187 were female which represents 50.4%. This compares to the statewide percentage of 49.6% for male and 50.4% for female.

The age distribution of an area can provide valuable insight into the region's economic composition and income potential. By national standards, Texas has a relatively young population. The 2010 Census estimates for Texas show a population composition as follows:

Age	RHP-12 Rural Percent	RHP-12 Urban Percent	RHP-12 Percent
Under 5	8	7.4	10.0
5-14	15.4	13.9	19.0
15-19	7.6	7.8	10.1
20-44	18.9	23.8	28.5
45-64	17.5	16.8	22.4
65+	8.4	7.0	10.0

According to the American Community Survey (2005-2010), across the entire region the average percentage of families with income below poverty in the entire region is 12.1%. However, when looking at families with children, the ratio is significantly higher at 19.4%. The rate increases to 26.8% when children under 5 years old are present in the house. Among all adults age 25 and over, 23.8% of them live in poverty. The average median earnings in 2009 for the population 25 and over were $27,415. An average of 14.9% of the population in the region's counties is linguistically isolated.

Poverty levels, income, and English ability correlate with education levels. In RHP-12, 12.8% of individuals older than 25 years old had less than a 9th grade education. In terms of educational attainment, 74.6% of all residents over 25 years old had a high school diploma or higher; 16.5% had a Bachelor's degree or higher; and 4.3% had a graduate or professional degree.

Texas Workforce Commission reported an average weekly wage during 3rd quarter 2010 for all covered wages and salaried employment in the RHP-12 Rural region to be $705.20 and in the RHP-12 Urban region to be $683.70. Average weekly wages for 3rd quarter 2011 was $761.01, an increase of 7.9%, and in the RHP-12 Urban region $718.97, an increase of 5.2%. This is compared to an increase of 6.3% statewide for the same period of time. The Texas statewide average weekly wage in the 3rd quarter of 2010 was $931.50. The wage data is the result of the reported quarterly wages and salaries paid by employers divided by 13 weeks.

The most recent civilian labor force estimates from the Texas Workforce Commission (TWC) for Texas statewide in April 2012 is 12,547,852 which is an increase in the labor force of 139,139 persons since April 2011. This represents a 1.1% change in Texas during this time period. These estimates are not seasonally adjusted. RHP-12 Rural had a civilian labor force of 187,016 for April 2012 which was a change of 1,745 since April 2011. This change represented an increase of 0.9% for the RHP-12 Rural study area. RHP-12 Urban had a civilian labor force of 279,611 for April 2012 which was a change of 4,576 in CLF since April 2011. This change represented an increase of 1.7% for RHP-12 Urban.

Compared to Texas, employment sectors in RHP-12 Rural changed at a higher rate for Construction, Manufacturing, Trade, Transport & Utilities and Other Services between 3rd quarter 2010 and 3rd quarter 2011. During that same time period, area employment for Natural Resources & Mining, Information, Financial Activities Group, Professional, Business & Other Services, Education & Health Services., Leisure & Hospitality Group and Public Administration changed at a lower rate when compared to Texas.

In the Urban area, employment sectors in RHP-12 Urban changed at a higher rate for Trade, Transport & Utilities, Prof., Business & Other Services, Education & Health Services and Public Administration between 3rd quarter 2010 and 3rd quarter 2011. During that same time period, area employment for Natural Resources & Mining, Construction, Manufacturing, Information, Financial Activities Group, Leisure &

Hospitality Group and Other Services changed at a lower rate when compared to Texas.

Top Manufacturers for the RHP-12 Rural Region:		
Name	**City**	**County**
American Cotton Growers	Littlefield	Lamb
Azteca Milling LP	Plainview	Hale
Cargill Meat Solutions	Plainview	Hale
Cargill Meat Solutions	Friona	Parmer
Caviness Packing	Hereford	Deaf Smith
Conoco Phillips Crude Terminal	Borger	Hutchinson
Hereford Svc	Hereford	Deaf Smith
Jbs Swift & Co	Cactus	Moore
Valero Mc Kee Refinery	Sunray	Moore
National Oilwell Varco	Varies	West Texas Region

Top 10 Manufacturers for the RHP-12 Urban Region:
Aramark
B&W Technical Svc Pantex
Beef Products
Bell Helicopter Textron
Industrial Molding Corp
Mrs. Baird's Bakeries
Owens Corning
Tyco Fire Products
Tyson Fresh Meats
X-fab Texas

- *Insurance coverage (e.g. commercial, Medicaid, Medicare, uncompensated)*

According to the Behavioral Risk Factor Surveillance System (BRFSS) (2010), 59.8% of residents had employer-based health insurance; 19.2% had Medicare; 4.0% had Medicaid; 2.7% had Veteran's Administration or Military Insurance; 0.6% had coverage through JO Wyatt or a District Clinic; and 0.3% had other coverage. 13.4% of residents were uninsured.

- *Description of region's current healthcare infrastructure and environment (e.g. number/types of providers; hospital sizes, services, systems, and cost; Health Professional Shortage Area (HPSA))*

The number of acute and psychiatric care hospitals in RHP-12 Rural as of October 2007 was 29, with an average total beds capacity of approximately 36.2 compared to a

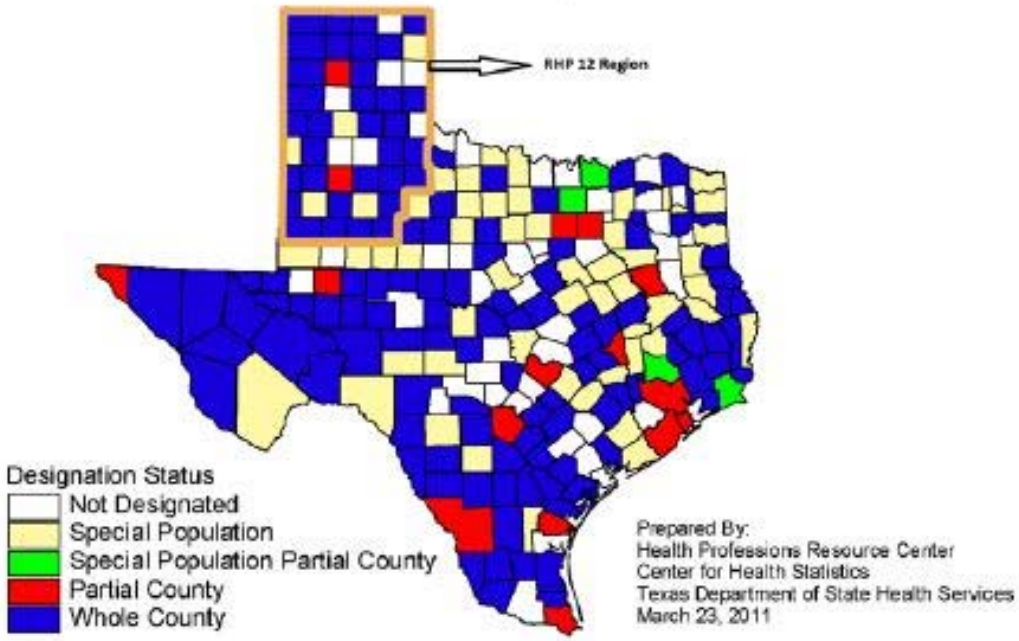
statewide ratio of 123.1 beds per hospital according to statistical reports from the Texas Department of State Health Services. The number of acute and psychiatric care hospitals in RHP-12 Urban as of October 2007 was 19, with an average total beds capacity of approximately 168.8 compared to a statewide ratio of 123.1 beds per hospital according to statistical reports from the Texas Department of State Health Services.

The Texas State Board of Pharmacy data for October 2007 shows there are 168 licensed pharmacies in the RHP-12 Urban study area and 122 licensed pharmacies in RHP-12 Rural.

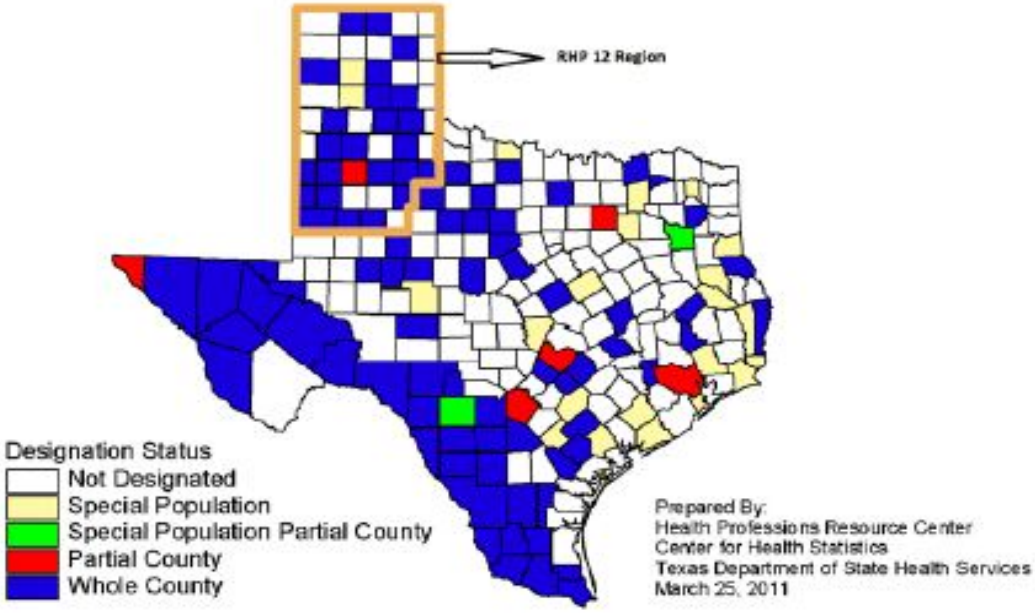
According to the Texas Department of State Health Services October 2007 report, there were 386 direct patient care and primary care physicians who practiced in the Rural region and 1,520 in the Urban region. Including primary care and specialty physicians, the ratio of total persons to each physician in the RHP-12 Rural area was 991.1 residents per each physician. The ratio of total persons to each physician in RHP-12 Urban was 323.3 residents per each physician. This compares to a statewide ratio of 460.5 persons for each physician in Texas. Although the urban ratio shows better ratios than the state, the area is home to a medical school with more than 300 residents who are factored into these ratios, but do not provide the same level of care or access as physicians who have completed their training.

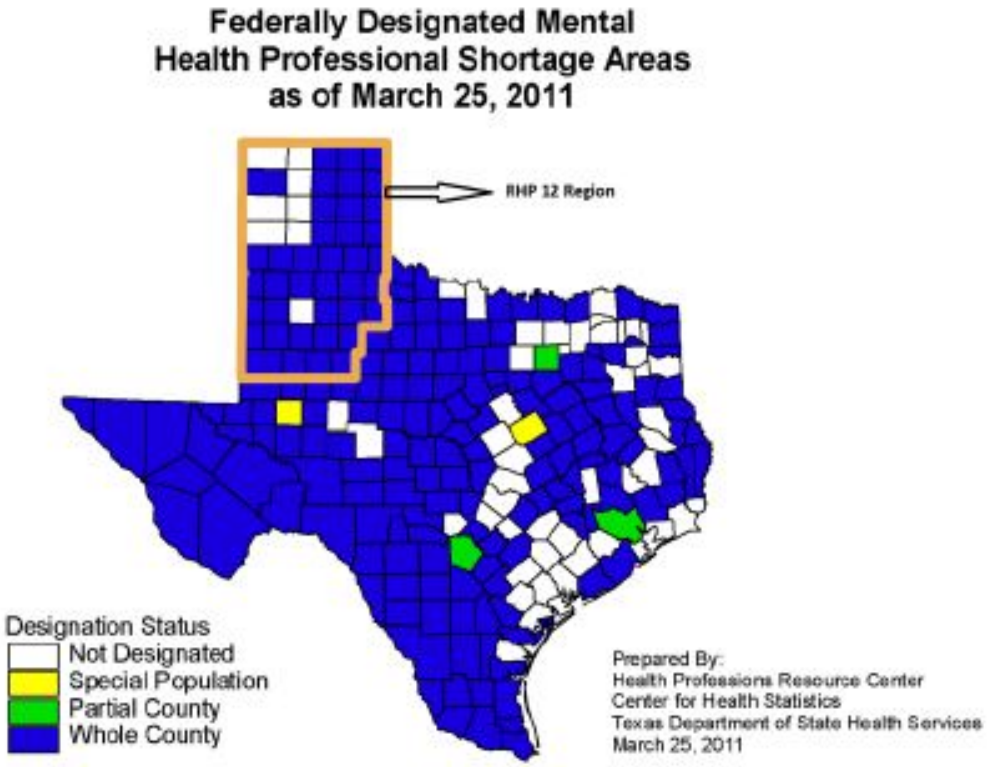
Federally Designated Health Professional Shortage Area of RHP 12 as of March 25, 2011 is shown on the maps following the tables at the end of the report. The map was created by the Primary Care Office at DSHS. The white counties are counties that have no designation at all, and this is typically because they lack enough population to make the Health Resources and Services Administration (HRSA) Health Professions Shortage Area (HPSA) matrix work and usually no doctors at all. The blue counties are counties that have been designated as entire county HPSAs after going through the matrix mentioned above. The specific reasons why each blue county was designated as a geographic HPSA have to do with patient-provider ratios as well as distance to care factors. The red counties have census tracts that fall into the same criteria as the blue, but not the entire county census tracts are deemed underserved by the distance and ratio factors. The cream colored counties and the bright green counties are either entire (cream) county designated, or partial (green) county designated based on needs of special populations. 99.9% of the time that translates to the county having plenty of providers, but far too few or none that will accept Medicaid, Medicare, CHIP, etc. As shown on the map, RHP 12 has a primary care shortage, dental care shortage and a severe Mental Health Care Shortage.

Federally Designated Primary Care Health Professional Shortage Areas as of March 23, 2011

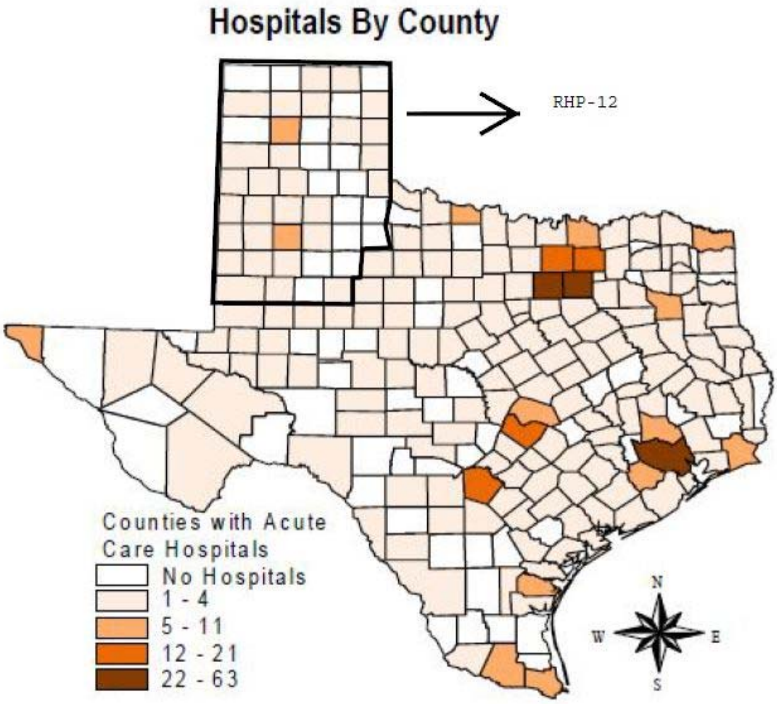


Federally Designated Dental Health Professional Shortage Areas as of March 25, 2011





Because of the rural and frontier nature of the RHP-12 region, many counties do not have acute care hospitals. In addition, there have been a number of hospital closings in recent years that has further reduced access for area residents. Within the RHP-12 region, 17 counties have no acute care hospital; 27 counties have 1-2 acute care hospitals; and 2 counties have more than 2. The following map from the Texas Department of Health Services illustrates the number of acute care hospitals in 2011.



- *A brief description of any initiatives in which providers in the RHP are participating that are funded by the U.S. Department of Health and Human Services. Refer to the Companion Document for a list of applicable federal initiatives.*

Texas Tech Health Sciences at Amarillo has one HRSA grant for the Pediatric residency. The funding amount is $960,000 for resident salary over a 5 year period. The second year of the grant began on July 1, 2012. This grant supports two salaries plus benefits. Texas Tech Health Sciences at Amarillo also has a State DSHS for Early Head Start Home Based Option (EHS), Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse Family Partnership. However, these funds cannot be used towards any matching funds. This is a fairly new project so no reimbursements have been received and the state has not finalized the budget.

South Plains Rural Health Services, Inc. in Levelland, Texas has a HRSA grant for $650,000 which supports the primary care services at a Federally Qualified Health Center.

Bailey County is in the final stage of a HRSA grant that was designed to expand the size of their Rural Health Clinic through a capital expansion. However, matching funding was not raised. Therefore, the scope of the grant changed to equipment only. This project will be finished by 12/31/12.

Nolan County reports the following grants that have US Department of Health and Human Services funding passed through the Texas Department of State Health Services. These grants are the Mental Health Block Grant; Title XX-Social Services

Block Grant; and Temporary Assistance for Needy Families (TANF). Nolan County also reports funding passed through Texas Department of Assistive and Rehabilitative Services Temporary Assistance for Needy Families (TANF) funding; Medical Assistance Program funding (Title XIX Medicaid); and ARRA-Medical Assistance Program (Title XIX Medicaid)

Cogdell Memorial Hospital of Snyder, TX in Scurry County reports a SHIP grant (Small Rural Hospital Improvement Program) from the state for physician peer review and IT infrastructure.

- *A brief description of any other relevant delivery system reform initiatives underway in the RHP region.*

  There are currently no other Medicaid or Medicare delivery system reform initiatives occurring in the region.

- *Projected major changes in items considered in the above five bullets expected to occur during the waiver period of FFY 2012 – FFY 2016*

The Office of the State Demographer for the State of Texas distributes the most widely used population projections for Texas. Projection estimates in these tables and the methodology for migration scenarios have been revised as of 2008 by the Texas State Data Center and Office of the State Demographer - now housed at University of Texas, San Antonio. Using this projection scenario, the following table represents population projections for RHP-12 Rural as computed in 2008 by The Office of the State Demographer for the State of Texas:

Population Projections and Percent Change Since 2000										
Year	Total	% Chg	Anglo	% Chg	Black	% Chg	Hispanic	% Chg	Other	% Chg
2000	20,851,820	---	11,074,716	---	2,421,653	---	6,669,666	---	685,785	---
2005	22,556,046	8.2	11,327,873	2.3	2,588,605	6.9	7,820,842	17.3	818,726	19.4
2010	24,330,646	16.7	11,533,976	4.1	2,754,751	13.8	9,080,459	36.1	961,460	40.2
2015	26,156,723	25.4	11,694,520	5.6	2,913,062	20.3	10,436,546	56.5	1,112,595	62.2

- *Key health challenges specific to region supported by data (e.g. high diabetes rate, access issues, high emergency department (ED) utilization)*

The following health data is sourced from the Behavioral Risk Factor Surveillance System (BRFSS). This data does present some limitations because of the ability of BRFSS to cover the rural and frontier areas. Therefore additional information is presented from the survey that the West Texas AHEC completed in association with the needs assessment for the RHP-12 initiative.

Vaccinations – In Amarillo 93.4% got needed vaccinations in 2010 compared to 89.2% in 2007. In the rural counties 5% of the phone survey said certain vaccinations were unavailable and 6% said their health coverage did not provide for vaccinations. 4% of adults did not have access to vaccinations. Of those age 65 and older, 30.3% have not had a pneumococcal vaccination and 36.7% had no flu vaccination within 12 months. Of those between 18 and 65 years 67.5% have had a flu vaccination within 12 months.

Excess Body Weight – In Amarillo 61.1% of the population had excessive body weight (overweight 32%, obese 28.4%) compared to 54.4% in 2007. Increasing obesity mirrors nationwide trends. Physical inactivity and diet are the major contributing factors according to surveys in both the rural and urban areas. Nationwide show the incidence is increasing.

Diabetes Mellitus – Patients surveyed who were told they have diabetes in 2010 (9.1%) and 2007 (11.0%) are compared to nationwide in 2009 (8.3%) and Texas 2007 (9.3%). Statistically there are many more cases of undiagnosed diabetes. Survey respondents indicated that 8.7% were told they had borderline diabetes and 4.3% of women said diabetes was diagnosed when they were pregnant. All national surveys show the incidence of diabetes is increasing. Approximately 1.8 million adult Texans have Type 2 diabetes and an estimated 460,000 are undiagnosed. Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause of death for African Americans and Hispanics. Approximately 21.9% of adults with diagnosed diabetes do not have health insurance. Lubbock BRFSS data indicate that 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 and is higher than the Texas rate of 26.5/100,000.

Heart Disease, High Blood Pressure and Stroke- 4.8% of Amarillo respondents in 2010 said they have had a heart attack or angina. Lubbock had a higher incidence of 7.1% with a nationwide at risk comparison of 4.0% in 2008. In the rural counties, 25% reported a household member with some form of heart disease; 7% cited someone in their household having had a stroke; and high blood pressure was cited by 56% as being prevalent in their household. In Lubbock 2.8% reported they had had a stroke. In Amarillo, the at risk rate for stroke was 3.2% in 2010 and 3.1% in 2009. The national at risk for stroke percentage is 2.4%.

Asthma - Respondents were asked if a doctor, nurse, or other health professional had ever told them they had asthma. 19.6% of the respondents had been told they had asthma. When asked if they still had asthma, 77 (66.4%) of the 116 respondents who had ever been told they had asthma answered “yes.” This equals 12.9% (“at risk”) of all 598 respondents.

This rate is higher than both the nationwide percentage (8.8%) and the Texas percentage (6.5%) in 2009. Asthma was higher among female respondents, Black/African American respondents, respondents with some college education, respondents with an income of $50,001 to $75,000, and respondents who completed the interview in English.

Tobacco Use – Amarillo respondents were asked if they had smoked at least 100 cigarettes (5 packs) in their entire life. A total of 42.9% reported having smoked at least 100 cigarettes in their life. The percentage of respondents who had smoked at least 100 cigarettes in their entire life appears to have decreased from 48.1% in 1999 to 44.3% in 2007 to 42.9% in 2010. The percentage of Amarillo 2010 respondents who had smoked at least 100 cigarettes in their life is equal to that of Nationwide 2009 respondents and higher than that of Texas 2009 respondents. The percentage smoking at least 100 cigarettes in their life ("at risk") decreased as education and income increased and was higher among male respondents.

Respondents who had smoked at least 100 cigarettes in their entire life were asked if they still smoked every day, some days or not at all. 32.0% still smoked every day while 11.6 percent smoked some days. 57% no longer smoked cigarettes. The percentage of those respondents who still smoke every day appears to have decreased from 44.2% in 1999 to 36.7 percent in 2007 to 32.0 percent in 2010. An "at risk" person is defined as one who has smoked at least 100 cigarettes in their entire life and still smokes every day or some days (111 respondents/598 total = 18.6%). In Lubbock current smokers were 20.9% and 43.6% smoked at some time in their lifetime.

In rural counties when surveyed about perceptions around tobacco use, 43% of respondents thought tobacco use was a problem, with 43% citing youth smoking as their basis, and 37% including use of smokeless tobacco and youth. Twenty-nine percent of respondents believed that the number of pregnant women who smoke is too high. Forty-six percent of respondents believed that the number of adults who smoke is too high. Lack of local enforcement of smoking bans was considered to be a problem by 24% percent of respondents and 25% of respondents were concerned about enforcement of minors purchasing tobacco products.

Mammogram Screening - Female respondents were asked if they had ever had a mammogram, an x-ray of each breast to look for breast cancer. The Amarillo BRFSS data indicated 62.0% of the female respondents reported having had a mammogram. Of women age 45 to 64, 15.8% have never had a mammogram. In Lubbock women of all ages reported that 26.1% have never had a mammogram. The percentage of the female respondents who had a mammogram increased as the age of the respondent increased, and was higher among Black/African American respondents, respondents with a college degree or more, and respondents with an income of $50,001 to $75,000. In the rural counties, opportunities and education regarding the need for mammograms are known to be low, although no specific data is available.

Pap Smear - Female respondents were asked if they had ever had a Pap test, a test for cancer of the cervix. 86.8 percent of those respondents answered "yes." It appears that a smaller percentage of female respondents reported ever having a Pap test in 2010 (86.8%) than in 2007 (90.3%). The percentage of female respondents who reported ever having had a Pap test was higher among Black/African American respondents and respondents with an income of $50,001 to $75,000. In Lubbock, 24.7% of women over

18 years of age have had no pap smear within 2 years. Female respondents who reported having had a Pap test were asked how long it had been since they got their last one. Survey information shows 73.7% of those respondents reported they had gotten their last Pap test within the past year (57.0%) or within the past 2 years (16.7%).

An "at risk" person is defined as a woman age 18 or older who has not had a Pap test in the past three years. The percentage of at risk women is lower for Amarillo 2010 respondents than Nationwide 2008 (17.1%) and Texas 2008 (18.5%) respondents. The percentage of female respondents over 18 years of age who were at risk because they had not had a Pap test in the past three years increased as the age of the respondent increased.

Rectal Exam - Male respondents were asked if they had ever had a digital rectal exam and 42.7% of those respondents answered "yes." It appears that the percentage of male respondents who had ever had a digital rectal exam had decreased to 42.7% in 2010 from 46.6% in 2007.

Male respondents who reported having had a digital rectal exam were asked how long it had been since they had the examination. 65.3% of those respondents reported having had this exam either within the past year (48.6%) or within the past 2 years (16.7%). In Lubbock 45.9% of males surveyed stated they had a rectal exam performed in the past.

Sigmoidoscopy or Colonoscopy - Survey results indicated 30.7% of the respondents indicated they had had one or the other of the exams. 38% of Amarillo 2010 respondents age 50 or older were at risk compared to 37.8% of Nationwide 2008 respondents and 43.8% of Texas 2008 respondents). The percentage appears to have increased when compared to Amarillo 2007.
Results show 40.4% of those respondents reported having one of these exams within the past year (22.2%) or within the past 2 years (18.2%). A smaller percentage of 2010 respondents (40.4%) than 2007 respondents (49.6%) reported having had a sigmoidoscopy or a colonoscopy exam within the past 2 years.

HIV Testing - The Survey indicated that 37% had been tested for HIV. The percentage of respondents who reported being tested for HIV generally decreased as the age of the respondent and income decreased and was greater among Black/African American respondents and respondents with children under 18 living in the household (see Table 83). 47% of those who had been tested for HIV were tested from between January, 2008 and August, 2010.

Mental Health - Mental disorders are present in 6% of the adult population. 20% of children have at some point in their life a seriously debilitating mental disorder. Mental disorders account for 25% of years of life lost to disability and premature mortality. Access in all of Texas is difficult due to insufficient providers and low funding levels. Fewer than half of the eligible mental health population received services in Texas. Only 41.7% of children ages 2 to 17 received care they needed. In the Lubbock area 18.8% of the adult population experienced 5 or more days of poor mental health. The 2010

Amarillo BRFSS data indicate 15% of respondents sought mental health services in the last two years.

The most common problem reported by respondents who sought mental health care was the inability to get an appointment (24.2%). Access in all of Texas is difficult due to insufficient providers and low funding levels. In the Lubbock Independent School District that 19% had felt sad or depressed most or all of the time in the last month and 18% reported attempting suicide at least once. 15% had engaged in bulimic or anorexic behavior. Lubbock County's rate for family violence was 90% higher than the Texas average and child abuse was 120% higher than the Texas average. Counseling services are offered on only a limited basis to Medicaid patients and worse to uninsured patients.

In the rural counties respondents were asked to report on mental health issues present in their households during the previous 5 year period. 22% of respondents reported a household member affected by depression or anxiety. Almost 3% of respondents had a family member attempt suicide. 3% of respondents also reported a household member who had been diagnosed with a mental illness other than depression/anxiety, and over 2% stated the condition was too severe for the member to maintain employment. Stress was a mental health issue reported by 25% of persons surveyed. 3% of respondents also reported a household member dealing with some form of eating disorder. When asked about their ability to receive help and support for these mental health issues, only 7% stated they were completely lacking a resource that would meet their needs, but 3% cited a lack of quality, affordable, accessible, mental health services in their local community, with lack of transportation affecting 4% of respondents. Less than 2% of respondents reported concerns around the perception of accessing mental health services.

Maternal Care Issues – Maternal health is a key determinant in long term health status. Fewer than one half of pregnancies are planned. In Lubbock County in 2007 only 58.1% of mothers received first trimester prenatal care. In Lubbock 41.7% of births are to unmarried mothers and 4.9% to mothers less than 18 years of age. Adolescent motherhood to Hispanics girls is 10.9%. For all groups low birth rate babies were 8.4% of the total births. Potter/Randall County has a very high rate per population of sexually transmitted diseases.

Dental Care – DSHS data indicate a severe shortage of dental care as do hospital needs assessments.

The assessment should inform the selection of DSRIP projects in Section V. The community need ID number shall be referred to in the project narratives in Section V.

Summary of Community Needs

ID #	Description of Problem Needing to be Addressed	Data Source
CRITICAL NEED		
CN.1	Severe primary care provider shortage, wait time, expense, lack of insurance, access to care	BRFSS data, Focus groups, survey, DSHS
CN.2	Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.	BRFSS data, survey, focus groups. DSHS data
URGENT NEED		
CN.3	Poor insurance support or uninsured.	BRFSS data and survey
CN.4	High incidence of obesity, diabetes mellitus and heart disease.	BRFSS data and survey
CN.5	Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease & other chronic diseases.	BRFSS data
CN.6	Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam	BRFSS data, survey, focus groups
CN. 7	Insufficient maternal and prenatal care, especially the first trimester teen pregnancy, high percentage of unmarried mothers	BRFSS data, survey, focus groups.
IMPORTANT BUT LESS URGENT		
CN. 8	Alcohol abuse and binge drinking, substance abuse	BRFSS data, survey
CN. 9	Tobacco use	BRFSS data, survey
CN. 10	High Prevalence of asthma and care issues	BRFSS data, survey
CN. 11	Inadequate vaccination of the population	BRFSS data
CN. 12	High incidence of sexually transmitted disease	BRFSS data
CN. 13	There is a shortage of dental care	BRFSS data, surveys, Hospital Needs Assessment
CN. 14	HIV Screening	BRFSS data

Section IV. Stakeholder Engagement

A. RHP Participants Engagement

Work on stakeholder involvement began when the Medicaid 1115 Waiver was approved in December 2011. Initially the Texas panhandle was divided into Region 12 and Region 16. However, during the participant engagement process the regions were merged, as described below, so now Region 12 is comprised of the former Regions 12 and 16. Jeff Dane, the Chief Financial Officer for University Medical Center, began discussions with Steve Beck at Covenant Health System, who then brought into the conversation Brandon Durbin, a well-known West Texas consultant who deals heavily with the rural hospitals in this region. This initial group then formed a list of all hospitals in the *original* Region 12, which at that time were only 25 counties not 47. From this list the team worked to get contact information for lead representatives at each facility, and subsequently created an email group.

The provider outreach in the original Region 16 began in Amarillo with the Coalition of Health Services, which is an organization of all Northern Panhandle Hospitals. Region 16's first step in their process was to have the Coalition of Health Services identify additional potential stakeholders. Kyle Sanders, then-CEO of Northwest Texas, suggested outreach to Matt Richardson, Director of Public Health in Amarillo and the Amarillo Hospital District. Mr. Richardson was contacted and the Amarillo Hospital District was tentatively named anchor of the *original* Region 16 (Moore County was later appointed anchor for the original region 16 prior to the final merger of the regions) Mr. Richardson then immediately initiated the involvement of Brandon Durbin, who was the same consultant used by the *original* Region 12 to gather a list of potential stakeholders.

The Original region 12's first stakeholder gathering took place on March 22,2012 in Lubbock, TX. Several members from the original region 16 were present at this meeting. The following meetings included participants from the proposed merged region. These additional regional stakeholder meetings took place on April 24th, May 22nd, July 17th, August 16^{th,} and September 13th. A meeting was scheduled for June 26th, but the executive committee cancelled due to significant direction change in the waiver and lack of confirmed information to share. The March, April, May, July, & September meetings were all face to face meetings with attendance recorded.

However, because of the size of Region and travel distances involved, alternative meeting formats were also offered. The August meeting was done via webinar. For the July and September meetings, two location options were provided utilizing technology at the Texas Tech University Health Science Center campuses. Stakeholders could attend the meeting in Lubbock or Amarillo face-to-face. They could also dial in for a live audio-only feed of the presentation.

In September the state distributed a list of Pass 1 Hospital Allocations. From this list, the executive committee reached out to all hospitals that were not actively participating in the waiver. Those included Cochran Memorial Hospital in Cochran County, and in Wheeler County, Parkview Hospital and Shamrock Hospital. All three hospitals opted out of DSRIP; two are participating as a UC-only hospital; and one is not participating at all.

One of the agenda items of the April regional meeting was a discussion of the proposed merger of Regions 12 & 16 (Amarillo). Representatives from both the original Region 12 and 16 were present at this meeting. It was voted on and decided by the two regions executive committee to move forward with the merger. UMC presented the proposed merger to the state at a public hearing in Austin on May 17th and received approval via the Final RHP map on May 31st.

At the May 22nd meeting, subcommittees were developed. (See Addendum 4). The most active of these subcommittees were the behavioral health & the community needs assessment groups in addition to the executive committee, which met regularly. From April to June, the executive committee met every other week face-to-face, and beginning in July the committee added a thirty minute conference call in the weeks without a face-to-face meeting. This schedule continued through September, but since then has decreased in frequency because of the significant project time required to work on the projects and on the RHP plan document completion. However, on October 1st and 2nd, UMC staff held work sessions in Amarillo and Lubbock. Partners were provided with one hour time slots for each to receive technical assistance in writing their DSRIP projects.

Quarterly, regional meetings will continue to be held and an option to participate via teleconference will continue to be available. Executive committee will have regularly scheduled monthly conference calls beginning in January 2013 with a planned duration of at least one hour going forward. All participants will also be encouraged to participate in a regional learning collaborative (being developed) and an open forum project discussion forum on our www.texasrhp12.com website.

B. Public Engagement

The consolidated Region 12 developed a website, www.texasrhp12.com, as a means of communication with the region and the public at large. All updates regarding the waiver and the region are present on this site and public comments were accepted through this website. The website also has a member section that contains resources, unique regional templates and other working documents specifically for RHP-12 members.

Regular and frequent email communication was used throughout the entire process on an as needed basis along with personal communication with each partner as questions arose. UMC strove to offer as much technical support as possible to the group.

In Mid-February, Jeff Dane attended the South Plains Association of Governments meeting along with several county judges where he gave a presentation on the waiver. On March 22nd, the first Region 12 stakeholder meeting was held. At this meeting, the executive committee for ORIGINAL Region 12 was established and the topics discussed included the need to identify additional stakeholders and local needs assessment that would need completed.

Two public meetings were organized in Amarillo before merger. One was for March 20, 2012, which was announced in the Amarillo newspaper and online. The second was held for Amarillo area stakeholders at the Amarillo Globe on April 23, 2012 with thirty-eight people in attendance. Power Point Presentation and sign-in sheets are available from the second meeting.

In July, UMC mailed letters to fifteen county judges representing counties in the region that do not have a healthcare facility in the county. UMC received one response from Oldham County Judge, Don Allred. After a discussion of the waiver and its requirements, he decided that because their indigent costs are so low there was not a need for them to participate in the waiver.

All major milestones in the current and future development and implementation of the RHP plan are accompanied by a public comment period through the website and periodic meetings if deemed appropriate by the executive committee. On November 8 and December 14, 2012, UMC hosted a teleconference/webinar to open the Region 12 plan to public comment. These meetings were posted in the Amarillo and Lubbock newspaper and at the region's www.texasrhp12.com website. Comments were accepted during the call, on the website, and for five days following the call. The Region will continue to follow this structure at every major milestone in the plan's development and implementation. The schedule for public comment will be posted on the Region 12 website.

Region 12 has a letter of support from the two major medical societies in the Region. The Potter-Randall Medical Society and the Lubbock, Crosby, Garza Medical Society have provided letters regarding their participation in the waiver process.

Section V. DSRIP Projects

A. RHP Plan Development

RHP-12 is a Tier 3 region. In Pass 1, the RHP-12 has identified 88 Category 1 and 2 projects with an associated 95 Category 3 outcome measures.

For the implementation of Pass 1, providers were notified of the available funding amounts and the valuation formulas that would be utilized to determine fundability. From there, local communities developed projects based on the results of the local needs assessment and according to how they felt they could most significantly impact the overall goals of the initiative. This has resulted in a set of projects that will significantly both the Urgent and Critical needs identified in the Needs Assessment. Rather than RHP-12 utilizing a top down methodology to direct project development, the governing body elected for an organic process that would allow local communities to address gaps and challenges as they found most appropriate. Because of the great distance between rural providers, it is difficult to develop “region wide” responses. The difficulty with administering such regional approaches become immobilizing in a region as vast as RHP-12. Therefore, the local approach elected by the governing body has mitigated that barrier, and the strategy of allowing local self-determination regarding projects has insured that the projects contribute towards the overall objectives and goals of RHP-12.

Although the majority of projects are being carried out by individual Performing Providers, multiple collaborations did evolve between partners. An example includes telemedicine project with Texas Tech Health Science Center and rural partners. The geographic isolation of the majority of communities impedes large collaborations across the entire region. Therefore, local communities have developed local responses that achieve the overarching goal of RHP 12, which is to address as many of the community needs identified in the assessment as possible.

A list of projects considered during Pass 1 and Pass 2 can be found in the attachments.

Because of the vastness of the area, the community needs assessment differentiated between the urban and rural portions of the region. This was needed because of the differences in the health care environments. The community level focus groups also reinforced this idea. This core issue of geography directed the regional approach and strategy for addressing the needs and goals. While recognizing the geographic barriers, at the outset, RHP-12 sought to develop a process and outcomes that were:

- Inclusive
- Maximize Financial Impact
- Maximize Impact on Delivery of Healthcare

The result of this framework produced a set of projects that 1) seek to address local needs as identified in the needs assessment; and 2) produce maximum impact by moving RHP-12 towards the triple aim goal of assuring patients receive high quality and patient centered care, in the most cost effective ways. This is being accomplished by impacting some of the least costly areas of care, namely primary care. In fact, the bulk of the projects outlined relate to providing expanded primary care as outlined by the following goals and objectives.

- Expand primary care capacity and quality
  - Decrease address non-emergent emergency room usage
  - Increase facilities for primary care
  - Increase patient centered medical home capacity
  - Increase prevalence of chronic disease management among providers
  - Improve ability to recruit providers
  - Increase access to mental health services

The performance improvement capacity goal aims to address issues that deter patients from seeking care and issues which negatively impact the health status of the region's patients. The strategies utilized to address the goal are grounded in evidenced based practices as outlined in guidance from CMS and HHSC. The patient tracking systems, reductions of preventable re-admissions, and the telemedicine initiative will also support the efforts of the primary care strategies described above.

- Enhance performance improvement capacity
  - Address patient satisfaction issues
  - Improving patient and disease tracking capacity
  - Reduce potentially preventable re-admissions
  - Utilize non-traditional service methodology such as telemedicine

Finally, the disease prevention activities also link to primary care in that these activities are aimed to increase knowledge about the importance of primary care, self-care, and increase availability of prevention and early detection services for cancer.

- Implement disease prevention activities
  - Implement health promotion activities
  - Increase availability of prevention and early detection services

While individual projects may not be region wide, local strategies are addressing the major goals of the region and specifically the critical and urgent goals outlined in the needs assessment.

Again, being inclusive, maximizing financial impact, and maximizing impact of the delivery of health care governed the process for evaluating and selecting projects.

Because the RHP-12 governing committee and anchor believed in the need for a participatory approach, the committee decided to use a primarily qualitative process rather than a strictly quantitative analysis to evaluate projects. In addition, the overwhelming majority of the participating providers are IGTs, because per instructions from HHSC, willing IGTs with viable projects could not be eliminated during the selection process.

Each entity was provided with the local and regional assessment data and asked to determine its priorities early in the process. These priorities were communicated in public meetings and were summarized and disseminated to eligible performing providers to inform them what IGT entities would be willing to fund. The anchor compiled proposals and facilitated meetings with the entities and performing providers to discuss their ideas and began to negotiate with the IGTs. As the planning protocol evolved, so did the projects.

Once the final planning protocol was approved, most of the performing providers and IGT entities had agreements in place as to what funds were available for which projects; the amount of DSRIP for the region did not approach the regional DSRIP cap. Based on this, RHP 12 proceeded through Pass 1 focused on meeting the Pass 1 requirements and ensuring that the eligible Pass 1 providers were able to include projects that would enable them to participate in Pass 2.

In terms of the review and evaluation processRHP-12 was divided into three areas: 1) North Rural; 2) South Rural; and 3) Urban. Sub-committees of the Executive Committee comprised of providers from each of these three sub-regions were formed. These sub-committees reviewed the proposed projects of the sub-region which they represented. During the process, projects were evaluated for the ability to address the needs identified in the needs assessment, adherence to the project areas, and duplication of efforts. When any duplication was identified or when opportunities for coordination and collaboration were identified, the sub-committee members would then provide such feedback to the performing provider(s) regarding the issues identified.

Hospitals that are exempt:

	Entity	TPI
1.	Muleshoe Area Medical Center	130877708
2.	Plains Memorial Hospital	136142011
3.	Childress Regional Medical Center	133250406
4.	Cochran Memorial Hospital	094152803
5.	Crosbyton Clinic Hospital	094141105
6.	Medical Arts Hospital	189947801
7.	Hereford Regional Medical Center	133544006
8.	WJ Mangold Memorial Hospital	126667806
9.	Memorial Hospital	094121302
10.	Hansford County Hospital	094117105
11.	Coon Memorial Hospital & Home	130826407

12.	Hemphill County Hospital	109588703
13.	Lamb Healthcare Center	127313803
14.	Lynn County Hospital District	094180903
15.	Ochiltree General Hospital	112704504
16.	Parmer Medical Center	137343308
17.	Cogdell Memorial Hospital	136330107
18.	Swisher Memorial Hospital	130721710
19.	Brownfield Regional Medical Center	130618504
20.	Shamrock General Hospital	
21.	Parkview Hospital	121787905
22.	Yoakum Hospital	137227806

B. Project Valuation

RHP-12 developed a valuation strategy that provided maximum self-determination to local performing providers. Funding allotments were determined and local providers were able to determine how the funds should be spent.

Because funding decisions were made by sub-committees of the Executive Committee along with the Finance Committee, local communities were able to evaluate the impact of peer projects and direct funding to those initiatives that provided the greatest overall impact to the community as determined by the impact on critical needs (as determined by the needs assessment); area population; and project scope. Therefore, two different Performing Providers might have similar projects with different valuations because of local geography barriers (i.e. frontier vs. urban); the complexity of need (i.e. after hours care vs. *new* primary care services); and the diversity of projects from any one Performing Provider. It is expected that similar projects with different valuations will produce different values in terms of the evaluation metrics.

Hospital Performing Providers had to comply with the funding distribution across Categories 1-4 for DY2 - DY5.

	DY 2	**DY 3**	**DY 4**	**DY 5**
Category 1+2	No more than 85%	**No more than 75%**	**No more than 70%**	**No more than 65%**
Category 3	At least 10%	**At least 15%**	**At least 20%**	**At least 25%**
Category 4	5%	**10 - 15%**	**10 – 20%**	**10 – 25%**

No projects are valued at more than $20 million in total over s DY 2-5, and hospitals that elected not to participate in category 4 shall allocate category 4 funding to categories 1 & 2 or 3.

RHP-12 utilized a set of criteria that were each worth up to five points. Each entity was then required to evaluate the project based on those criteria, which were: 1) achieves waiver goals; 2) address community needs (as identified by the needs assessment); 3) project scope/size; and 4) project investment.

For each proposed project, the scores across each of the criteria in the proposed methodology were summed to produce a total score. Using this assessment, Performing Providers and sub-region committees were able to value projects for submission to the RHP Plan. Performing Providers were advised that they may need to adjust the number of projects and/or the project values upon consideration of such factors as availability of local matching funds (IGT) and consistency of project valuations across the region. Many providers also conducted more detailed valuations for their projects by assessing the anticipated investments and community benefit, particularly savings resulting from avoiding unnecessary healthcare costs, and the relationship to other projects in RHP-12. Again, because of the geographic barriers, there was an emphasis on identifying potential linkages with other regional providers and how the project could tie into proposed learning collaboratives. Furthermore, the Community Mental Health Centers worked together with their industry association to engage a health economist in valuing their projects. This was important since many of their projects cross regional boundaries and these organizations placed great emphasis on ensuring consistency throughout the state.

C. Category 1: Infrastructure Development

Project Option: 1.1.2 Expand Primary Care Capacity, Expand Existing Primary Care Capacity
Performing Provider: Brownfield Regional Medical Center/130618504
Unique Identification Number: 130618504.1.1
Project Components: 1.1.2.a-c

Provider: Brownfield Regional Medical Center (BRMC) is an acute care facility operating under Terry Memorial Hospital District. BRMC is currently staffed for 26 beds but is licensed for 45 beds. BRMC's primary service area is Terry County, but secondary service area extends to surrounding counties and parts of eastern New Mexico. The total service area population is estimated at around 28,000.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, additional physician hours, and needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.4), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to primary care.

Target Population: The target population is residents of Terry, Gaines, Dawson, and Yoakum Counties that currently do not have sufficient access to primary care. We expect to serve approximately 1,132 new clinic patients by DY5 with a Medicaid and indigent share of at least 20%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve BRMC's primary care capacity, as evidenced by an 8% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 4% in DY 4 and 8% in DY 5.

Project Option: 1.1.2 Expand Primary Care Capacity, Expand Existing Primary Care Capacity

Performing Provider: Brownfield Regional Medical Center/130618504

Unique Identification Number: 130618504.1.1

Project Components: 1.1.2.a-c

Project Description: Brownfield Regional Medical Center's (BRMC) goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended hours in BRMC's physician clinics, adding support staff and physician hours. More specifically, BRMC proposes to extend clinic hours by approximately 8 hours, but is testing a number of options to see what best fit our patient needs. The target population for expanded access is new BRMC primary care clinic patients from Terry, Gaines, Dawson, and Yoakum Counties as of DY 3. The five-year target goal is to improve BRMC's primary care capacity, as evidenced by an 8% increase in primary care encounters.

The Brownfield community and all of West Texas have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

The overall vision for the Region 12 RHP is to assure residents receive high-quality, patient-centered care, in a cost effective manner that focuses on coordinated care delivery and improved health outcomes, with a particular focus on the Medicaid and uninsured residents, while containing cost growth. BRMC is partnering in the region's vision to fulfill as many of the community needs identified in the area as possible focusing on those identified as urgent and critical needs. These include improving quality and performance, increasing access to care, and increasing prevention and early detection activities. In order to meet the healthcare needs of our population within Northwest Texas, BRMC is proposing to expand primary care capacity. Expanding primary care access meets two community needs outlined by RHP 12, including: severe primary care provider shortage, wait time, expense, lack of insurance, access to care **(CN.1)** and high incidence of obesity, diabetes mellitus and heart disease **(CN.4)**.

Starting Point/Baseline: In FY 2012, the BRMC clinics saw a baseline of 14,154 clinic visits. Offering extended clinic hours will expand service availability to those not currently utilizing primary care services, traveling for their primary care needs, and provide better options for the employed population. As described in more detail below, extended hours is expected to increase the number of clinic visits by 1132 visits (8%) over the baseline of 14154 by DY5.

Rationale: BRMC's reason for selecting the expansion of existing primary care capacity project option is to increase the availability of primary care clinic services, translating to a healthier population and decreased hospital utilization. BRMC has chosen milestones for increased volume because providing more appointment availability and more clinic visits promotes expanded access to preventive care. Expanded service hours will allow patients to come at their convenience and have better access to care. Furthermore, the relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans.

As sited in the community needs assessment **(CN.1 and CN.4)**, there is a widespread critical shortage of primary care capacity and access to chronic disease management. More appointment availability will allow patients to come at their convenience and have better access to primary care.

As part of our plan to expand existing primary care capacity, BRMC will meet the required core components of the project. The proposed extension of clinic hours to include multiple nights and weekends will be a significant enhancement to their current clinic hour initiative of one night per week. Expanding the clinic staffing with nursing, clerical, and provider services will be necessary to cover the additional hours and patients. There is available space in the clinic that will be used to service the increase in the number of patients seen in the clinic.

It is difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent) (Pitts et al.)." Extending service hours will also provide better access to primary care because of the distance traveled for a clinic visit. In rural areas, it's difficult for patients to get to a clinic before it closes at 5:00 when they have to drive 30 minutes after getting off of work for the day. Likewise, the commute is difficult in the morning because it could take 2-3 hours out of their work day.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.

In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. beneficiaries "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." The evidence of decreased admissions and ED visits revealed in these primary care based pilots shows that preventive care can lead to lower overall utilization and cost. Applying this utilization data, the chart below shows the estimated annual savings of expanding primary care access through extended clinic hours:

Estimated Annual Savings - Extended Clinic Hours	
Total New Clinic Patients	*1,725*
ED visits/year/person	*0.45*
Potential ED Visits	*778*
ED Visits Reduced @ 15%	*117*
Average ED Payment	*$ 425*
ED Savings	***$ 49,596***
IP Admissions/year/person	*0.11*
Potential IP Admissions	*197*
Admissions Reduced @ 18%	*35*
Average Total Medicare Costs/Discharge	*$ 12,354*
IP Admission Savings	***$437,141***
Total Estimated Savings	*$486,737*

Related Category 3 Outcome Measure(s): The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). BRMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years, by 4% in DY 4 and 8% in DY 5. It is important to note that it is our belief that both this project to expand primary care clinic

hours and capacity and our second project to develop a patient navigation service will both serve to reduce ambulatory care sensitive conditions admission rates, but each has its own goal.

We propose to increase the overall quality of care and improve the health status of our target population—new BRMC primary care clinic patients as of DY 3. Extending clinic hours to nights and weekends will promote higher quality healthcare to our patients at an overall lower cost to payers. Extending primary care clinic hours will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours will prevent future ambulatory care sensitive admissions.

Relationship to other Projects: The BRMC clinic will begin offering extended hours (*130618504.1.1)* to provide additional appointment availability that will expand overall access to primary care. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (*130618504.3.1*) due to enhanced physician-patient relationships and preventive care.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative: BRMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Furthermore, our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Our extended clinic hours will assure that patients receive high-quality and patient-centered care, in the most cost effective ways. Providing primary care in the clinic setting is certainly the most cost effective—much more efficient than the ED or inpatient hospitalization. The expanded availability of hours will establish a patient-centered mindset.	**5**

	Primary care will better serve the Medicaid and uninsured residents of the greater Brownfield community much more effectively than the ED—having access to follow-up and preventive care. Extending clinic hours to nights and weekends will promote higher quality healthcare to our patients at an overall lower cost to payers. Extending primary care clinic hours will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. This project primarily impacts Medicaid and/or uninsured residents since this population is most likely to receive primary care in the ED and be disconnected from a primary care provider. Expanding hours and appointment availability will move the dial considerably to expand primary care access. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)." In addition, the March 2012 Executive Newsletter for HealthGrades reported that WellPoint, Inc. beneficiaries "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." The evidence of decreased admissions and ED visits revealed in these primary care based pilots shows that preventive care can lead to lower overall utilization and cost. (Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)	
Addresses Community Need(s)	As sited in the community needs assessment (CN.1 and CN.4), there is a widespread critical need and shortage of primary care capacity and access and chronic disease management. More appointment availability through extended clinic hours will allow patients to come at their convenience and have better access to primary care. There is peer-review literature suggesting that extended hours will help to keep patients in a primary care clinic instead of the ED during nights and weekends. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."	**5**
Project Scope/Size	BRMC expects to see about 1,132 new patients by DY5. Considering the small population (~18,600) of Terry County, that is a considerable degree of primary care expansion. The March 2012 Executive Newsletter for HealthGrades reported that WellPoint, Inc. beneficiaries "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." The evidence of decreased admissions and ED visits revealed in these primary care based pilots shows that preventive care can lead to lower overall cost.	**5**
Project Investment	The extended hours will require additional physician, RN, and clerical staffing. It will also require additional IT and overhead expenses for reporting category 3 measures. Since we have no other projects, the relative investment is high.	**5**

130618504.1.1	1.1.2	1.1.2.a-c	Expand Primary Care Capacity	
Brownfield Regional Medical Center			130618504	
Related Category 3 Outcome Measure(s):	130618504.3.1		3.IT-2.11	Ambulatory Care Sensitive Conditions Admissions Rate
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline **Baseline/Goal:** Expand clinic hours over current operating hours by approximately 8 additional hours. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $459,956	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 566 (4%) over baseline visits of 14,154 **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $533,150		**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 849 (6%) over baseline visits of 14,154. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $538,660	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 1,132 (8%) over baseline visits of 14,154. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $461,512
Year 2 Estimated Total DSRIP: $459,956	Year 3 Estimated Total DSRIP: $533,149		Year 4 Estimated Total DSRIP: $538,660	Year 5 Estimated Total DSRIP: $461,512
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): **$1,993,278**				

Project Option: 1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.
Performing Provider Number/TPI: Central Plains Center/127374005
Unique Project ID: 127374005.1.1 – **"PASS 2"**
Project Components: 1.11.2.a-h

- **Provider:** Central Plains Center, CPC, will be the provider. CPC is a community-based mental health and intellectual disabilities center serving 9 rural and frontier counties which is 10 000 square miles and approximately 92,000 people. We provide mental health services to on average 465 adults and 125 children. We also provide intellectual disability services to 120 individuals. CPC also offers early intervention services to babies, birth up to 3 years of age and residential substance abuse treatment for adolescent boys. In our RHP, we are the only provider of these specific services in our nine-county service area.
- **Interventions:** Specifically, the intervention will be the provision of psychiatric and other mental health services via telemedicine for 5 additional counties. This intervention will seek to decrease the burden on individuals residing in Parmer, Castro, Floyd, Motley and Briscoe counties that exist due to the need to drive up to 90 miles one way to receive psychiatric services. This intervention will allow individuals to receive psychiatric services in their home county, or a county close to them. This project will also connect our children's psychiatrist to all of our remote locations throughout our service area, expanding the availability of this service to underserved counties.
- **Need for the project:** Currently, individuals in the designated counties have had to travel up to 90 miles one way to receive psychiatric services for the mental health disorders. We currently operate two remote locations and this project double the number of remote sites we operate. Additionally, many of these counties do not have a children's psychiatrist available in their county and this project will expand that service.
- **Target Population:** This project seeks to provide telemedicine services to 25 adults residing in the designated rural and frontier counties and 25 children residing in Parmer, Swisher, Briscoe, Motley, Floyd, Bailey, Lamb and Castro counties. Our Medicaid rate for adults is 31% and our indigent rate is about 60% so about 91% of the encounters will be delivered to this population. Our Medicaid rate for children is 62% and our indigent rate is about 20% of children with no payer source, so about 82% of the encounters will be delivered to this population.
- **Category 2 expected patient benefits:** Because we serve rural and frontier counties we anticipate to provide between 35-50 telemedicine encounters in these designated counties.

- **Category 3 outcomes** - TBD

Project Option: 1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.
Performing Provider Number/TPI: Central Plains Center/127374005
Unique Project ID: 127374005.1.1 – **"PASS 2"**
Project Components: 1.11.2.a-h

Project Description: As a center, we have been providing telemedicine services to three of the counties in our service area since 1999. This project will allow us to expand our network to include four additional rural/frontier counties; Floyd, Briscoe, Motley and Castro Counties. We will install remote sites in Floydada and Dimmitt to better serve those counties and the surrounding counties via telemedicine with our psychiatric services as well as crisis services. We also want to enhance our current telemedicine connection with our children's psychiatrist by installing a point to point connection using fiber optic cables with him and his advanced nurse practitioner in Lubbock. Barriers we anticipate are finding the right location for the remote sites and we are will work closely with county and hospital representatives to find the right locations. We expect that in five years we will be able to give our consumers residing in Castro, Floyd, Motley and Briscoe Counties the option of receiving telemedicine psychiatric services. This project is related to the regional goals in that it improves access to medical services in small rural counties while decreasing the cost for this service by not having to pay a psychiatrist and children's psychiatrist to travel to these counties. It also eases the burden on consumers of mental health services in that it decreases their costs for traveling to receive these services.

Unique community need identification numbers the project addresses:

ID #	Description of problem needing to be addressed	Data Source
CN.2	Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.	BRFSS data, survey, focus groups. DSHS data

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-

to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Starting Point/Baseline: Beginning baseline is zero

Rationale: By expanding our current telemedicine network capacity we will essentially be doubling the number of counties we currently provide telemedicine services to. Also, by developing the point-to-point connection with our children's psychiatrist he will be able to connect to any of our four telemedicine sites which will bring children's psychiatry to counties that have not have that service available to them in their home counties. Up until now, children and adolescents from our nine counties have had to travel to Plainview for this service, which in some counties is over one hour of travel one way. The community need this addresses is CN.2, which identifies a lack of mental health providers in our area as a critical need.

Project Options: We will complete the following components:

a) We will not develop administrative or clinical protocols because we have been doing telemedicine since 1999 and have established and DSHS-approved protocols in place.
b) We will not be conducting a pilot as we believe we have already identified the need with the successful use of our other telemedicine locations.
c) Our telemedicine network will be in-house and only serving the consumers of Central Plains Center. We have already identified and trained our employees who will be utilizing the telemedicine equipment. We will not identify any additional providers at this time.
d) Since we have been providing telemedicine services since 1999 we already have our billing service codes identified for electronic encounters for our physicians. We will identify other services that will be provided via telemedicine. We will utilize modifiers we currently use on other electronic encounters.
e) We will begin to develop and implement data collection and reporting standards for electronically delivered services.
f) We will periodically review the intervention's impact on access to specialty care and identify opportunities to expand to a broader patient population
g) We will determine the need for scaling up the project according to identified community needs.
h) We will assess the impact on patient experience outcomes.

Milestones/Metrics: While we have been providing telemedicine for some time, this project represents a new initiative for us by expanding into new counties. The population we serve is, by nature, low income with very little resources. The counties we seek to serve with this project have not had psychiatric services located in their counties; they had to drive 30 to 65 miles to get this same service. We selected milestones and metrics that would enable us to quickly get the project functioning. The counties we seek to serve are designated as frontier and as the designation indicates, resources are very limited. We selected our metrics in a way that would allow us to increase accessibility and availability of needed adult and children psychiatric services in these frontier counties.

Related Category 3 Outcome Measure(s): TBD We are a non-hospital provider and have not determined Category 3 Outcome Measures.

Relationship to other Projects: This project will work at times with our other project on integrating behavioral health and physical health services. It will be important for our peers to have good working relationships with members of our medical community in order to ensure ease of access to needed medical services. Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project meets the triple aim of assuring patients receive high-quality and patient-centered care in the most cost effective way most significantly by addressing the lack of mental health providers in our rural counties. This project will enhance the health care infrastructure by increasing the number of mental health providers. The project further develop and maintain a coordinated care delivery system by being an integral cog in the wheel of linking individuals to needed mental health and psychiatric services. Cost growth is contained by decreasing the costs put on the patients for travel and by not having to pay our physicians to travel to these rural locations?	**4**
Addresses Community Need(s)	This project addresses the community needs by addressing the lack of mental health providers in our RHP. Individuals residing in our target counties have had to travel up to 65 miles to receive psychiatric services and one can assume this has prevented individuals in seeking needed mental health services. We have been doing telemedicine in two of our counties for individuals residing in Parmer, Lamb and Bailey counties. We have had great success with this in that we are able to bring mental health services to people where they live.	**4**
Project Scope/Size	The target populations of this project are the adults and children receiving mental health services from Central Plains Center. Although the total number served will be limited initially, we expect to expand the target population within the life of the project.	**4**
Project Investment	This project will require a big investment in IT equipment, software and maintenance to get started. Including getting stable and reliable high speed broadband connection in the Frontier communities. We will have annual costs in human resources training and maintaining broadband connection. Meeting the timeline in implementing this project should be relative simple because of the organization, legal, professional and staff support that is available. During this time we will be evaluating the risk assessment over the years and make adjustments as identified.	**3**

127374005.1.1 – "PASS 2"	**1.11.2**	**1.11.2.a-h**	**Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.**	
Central Plains Center			**127374005**	
Related Category 3 Outcome Measure(s):	**127374005.3.3**	**IT-- TBD**	**TBD**	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-4. Milestone: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment P-4.1. Metric: Inventory of new equipment purchased Data Source: Review of inventory or receipts for purchase of equipment Goal: purchase telemedicine equipment Estimated Milestone Incentive Payment: $ 48,826 P-5. Milestone: Procurement of Broadband Connection P-5.1. Metric: Documentation of presence of active broadband connection Data Source: Review of purchase receipt or demonstration of equipment Goal: Establish broadband connection in designated counties	P-7. Milestone: Hiring of tele-presenters, as needed, for remote site equipment operation. P-7.1. Metric: Documentation of acquisition of proper staff / training to operate equipment at remote locations Data Source: Interviews with staff, review of hiring or payroll records Goal: Tele-presenters hired and/or current employees identified for remote site operation. Estimated Milestone Incentive Payment: $73,141 P-8. Milestone: Training for providers / peers on use of equipment / software P-8.1. Metric: Documentation of completions of training on use of equipment /software		I-15. Milestone: Satisfaction with telemental services I-15.1. Metric: 50 % of consumer, peer and provider surveys indicate satisfaction with telemental services Data Source: Satisfaction survey results. Goal: 50%, or 25 consumers satisfied with telemental services. Estimated Milestone Incentive Payment: $148,918	I-15. Milestone: Satisfaction with telemental services I-15.1. Metric: 80 % of consumer, peer and provider surveys indicate satisfaction with telemental services Data Source: Satisfaction survey results. Goal: 80% or 40 consumers are satisfied with telemental services. Estimated Milestone Incentive Payment: $138,332

Estimated Milestone Incentive Payment: $ 48,826 P-6. Milestone: Establishment of the Remote Site Locations where equipment /software will be available to consumers P-6.1. Metric: Documentation of completion of site acquisition Data Source: Purchase, lease, grant, or rental agreement Goal: Remote site locations will be identified and established. Estimated Milestone Incentive Payment: $ 48,825	Data Source: Training roster. Goal: Tele-presenters hires and/or current employees trained for remote site operation. Seek to train 8 employees. Estimated Milestone Incentive Payment: $73,140		
***DY 2 Estimated Milestone Bundle* Amount:** $146,477	**DY 3 Estimated Milestone Bundle Amount:** $146,281	**DY4 Estimated Milestone Bundle Amount:** $148,918	**DY5 Estimated Milestone Bundle Amount:** $138,332
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$580,008*			

Project Option: 1.6.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.
Performing Provider Number/TPI: Childress Regional Medical Center/133250406
Unique Project ID: 133250406.1.1
Project Components: 1.6.2.A-C

Provider: Childress Regional Medical Center is a 39-bed hospital located in the city of Childress, Texas. The hospital is the primary healthcare provider for 30,000 residents in a 5 county area of the southeastern Texas panhandle; all 5 counties are HPSA designated.

Interventions: This project will implement nursing telephone triage for area patients.

Need for the Project: When primary care clinics are closed, the Emergency Room is the only place to access healthcare, resulting in a very high ratio of non-urgent ER patient encounters and very expensive after-hours primary care.

Target Population: Approximately 4,512 patients that presented to the ER with non-urgent conditions in 2012. 94% of ER visits in 2012 resulted in charges for non-urgent care. Poor utilization is a significant and costly problem. Patients with primary diagnosis of CHF are included, and the service is expected to reach ~1,000 patients over the life of the project. About 30% of our ER visits are Medicaid or indigent. The number of patients served by our urgent medical advice project is estimated to be at least 400 per year.

Category 1 or 2 Expected Patient Benefits: Patients will receive the appropriate level of care in the appropriate setting. Triage nurses will be able to guide these patients to a primary care site.

Category 3 Outcomes: Current hospital CHF readmission rate is 26.1%. By better coordinating care for this chronic condition, we expect to reduce that readmission rate to less than 5% during the 4 year project period.

Project Option: 1.6.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.
Performing Provider Number/TPI: Childress Regional Medical Center/133250406
Unique Project ID: 133250406.1.1
Project Components: 1.6.2.A-C

Project Description:

There is only one clinic in Childress, which is a county designated as a HPSA. When that clinic closes, the local emergency room is really the only place for patients to access care – regardless of the urgency of their condition. And when patients call our hospital with anything but very simple health related questions, our nursing staff is compelled to instruct them to come to the ER for evaluation…which is essentially the equivalent of a physician practicing defensive medicine…we don't want to miss anything. The result is a very high ratio of non-urgent ER visits, and very costly after-hours primary care.

Our collaboration with Crosbyton was the result of a good relationship and realization that a minimal allocation in the first pass (~$300k) would not be enough to support a meaningful or sustainable project. The hospital in Crosbyton wanted to partner with another rural hospital and improve the funding opportunity for our facility, so we developed an agreement. Because the funding amount was so small, we didn't dedicate it to a single project, but rather added it into our total allocation ($1.9m). Both of our pass 1 projects (medical home and urgent medical advice) have potential to have a transformative to the patients in our area. We hope to help patients access our system appropriately, drive down non-urgent ER use and get patients in a primary care setting that does a better job of caring for their chronic conditions. Our collaboration with Crosbyton, although relatively immaterial, is certainly helpful.

Goal: We hope to initiate a telephone triage system that helps patients navigate the system. Our goal is to improve community health, rely less on care delivered in the ED, avoid hospitalizations, and provide a better overall experience while driving down costs.

Challenges: Because of our rural location and geographic isolation, after-hours calls will present challenges. We don't foresee other major challenges because local clinicians have requested the service, and our only reluctance has been the associated costs. There might be some initial

reluctance from patients who resist change. We will address that challenge by clearly communicating options and benefits to patients.

Relationship to Regional Goals: This project supports the critical regional need (CN2): Lack of mental health services, inability to get an appointment, lack of insurance, *need to use ERs for initial contact.*

5 Year Expected Outcome: Over 5 years, we would expect to have a robust telephone triage system that serves both the hospital and our patients very well. This project supports the regional goal of reducing non-urgent ED utilization. Target population for this project will be patients treated in our ER with primary diagnosis of CHF.

Starting Point/Baseline:

There is no formalized local system for providing urgent medical advice currently (0% in February 2013).

Rationale:

We selected this project option because we see a real opportunity to revolutionize care in our community. We are aware of the alarming rural ED utilization trends (rural relevance study by Ivantage in June 2012 showed patient acuity in rural emergency department is relatively low – over 50% of visits are low acuity – compared to published national benchmarks for all emergency departments – 34% of visits are low acuity). The urgent medical advice line is a new initiative for our medical community and gives us a tool to counter the prevailing trend.

We have chosen milestones and metrics for this project that will prompt planning and protocols, education resources and eventual patient utilization of the service to support care decisions.

This project will cover core components; it addresses a critical community need (CN.2 – inability to get an appointment, lack of insurance, need to use ER's for initial contact). There are no projects with related funding from U.S. Department of Health and Human Services. A review of local data shows that 94% of YTD 2012 ER visits are charged as non-urgent.

This project will cover core components:

Process development: we will develop a call center that triages patients to a primary care site. Because of our rural location and geographic isolation, after-hours calls will present challenges. We will survey patients to ensure their satisfaction with the nurse advice line.
Enhance linkages: we will work to develop improved communication between our primary care (clinic) and emergency departments.
Quality Improvement: we always want to get better, so we'll use lessons learned and setbacks to improve the quality of the program.
This project addresses a critical community (and regional) need. The regional plan identifies inability to get an appointment, lack of insurance, need to use ERs for initial contact as a critical need (CN.2).
There are no projects with related funding from U.S. Department of Health and Human Services.
Local data shows that 94% of YTD 2012 ER visits are charged as non-urgent.

Related Category 3 Outcome Measure(s):

Potentially preventable readmissions (PPR) related to primary diagnosis of CHF (OD-3.IT-3.2) was selected as a stand-alone outcome measure related to our urgent medical advice project.
- THA Datagen report shows CRMC readmission rates specific to CHF at 26.1% (well above the national average)
- Better information and advice have proven to reduce readmission rates by improving utilization patterns.
- Low-income populations are disproportionately affected by poor utilization patterns and/or uncoordinated care. And low-income patients' health will improve when they get the care they need in the right setting (primary care).
- Preventable readmissions cost our region and our healthcare system billions of dollars every year. This project aims to reduce costs for our area.

Relationship to other Projects:

Healthcare delivery innovation projects are symbiotic. Medical homes (2.1) and Urgent Care Advice (1.6) will drive down non-urgent ED visits. Primary care capacity (1.1) building will improve

access and support the medical home philosophy. And providing appropriate care in the appropriate setting will result in fewer readmissions, fewer HAC's, less overall healthcare spend, and fewer preventable readmissions. This project really does provide a win-win-win situation for patients, providers, and the system.
Because of our rural location and relatively low volumes, we won't be reporting category 4 measures.

Relationship to Other Performing Providers' Projects in the RHP: We are not aware of another provider in our RHP that is attempting an urgent medical advice project, but we'd be happy to participate in learning collaborative at any point during the project. We would view that as a useful development.

Plan for Learning Collaborative: If a peer regional provider were to take on a similar project, we would suspect a monthly conference call and annual face to face meetings would allow us to share successes and failures. Our RHP anchor has also developed an online forum tool that could be utilized to share developments in real time. Together, we could troubleshoot and develop best practices.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Our urgent medical advice project will have great impact on achieving waiver goals: • Urgent medical advice is a patient service. • Childress county Medicaid and uninsured patients disproportionately access their care in the ER…often for non-urgent care. We can better serve these patients through better triage and guiding them to care in a primary care setting. • Urgent medical advice improves utilization and contains cost growth • Evidence suggests telephone triage can have a significant impact on non-urgent ED care and hospital readmissions	**5**

Addresses Community Need(s)	Care guidance is a major issue and community need in rural Texas…especially in designated HPSA counties. Childress County is underserved in terms of both physicians and nurses. Everyone works hard and is spread thin, so inappropriate utilization is a problem that can be addressed with urgent medical advice. The linkage concepts in this project are good for fractured clinic and emergency department communications. By putting a telephone triage system in motion, and working through issues as they arise, we will have met a significant community need.	**5**
Project Scope/Size	We are only proposing one other project due to the limited nature of our allocation. Medical home is our major planned initiative, but urgent medical advice is our secondary project. It has the potential to save significant dollars associated with non-urgent ED utilization and hospital readmissions by helping our patients get the care they need in the appropriate setting.	**4**
Project Investment	We are only proposing one other project due to the limited nature of our allocation. In terms of investment, both projects are similar. We will be required to make a significant investment in the telephone triage system. We will be required to make smaller investments in education (both patient and provider), training, data collection, policy and protocol development, and quality improvement activities.	**4**

133250406.1.1	1.6.2	1.6.2.A-C	Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.
Childress Regional Medical Center			**133250406**
Related Category 3 Outcome Measure(s):	**133250406.3.1**	**IT-3.2**	**Congestive Heart Failure 30 day readmission rate**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-1]: Establish clinical protocols for an urgent medical advice line Metric 1 [*RHP PP Metric* – P-1.1]: Submission of complete protocols Baseline/Goal: Baseline: No protocols (2/13) Goal: Complete protocols Data Source: Protocol Documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $212,686	**Milestone 2** [P-6]: Inform and educate patients on the nurse advice line. Target population is 25% of all ED visits (roughly 5,000 total visits per year). Metric 1 [P-6.1]: # or % of targeted patients informed/educated Baseline/Goal: Baseline: 0% (2/13) Goal: 25% of targeted patients Data Source: Hospital Electronic Medical Record Estimated Milestone 1 Incentive Milestone 2 Estimated Incentive Payment: $246,531	**Milestone 3** [I-13]: Improvement: Increase in the number of patients that accessed the nurse advice line Metric 1 [I-13.1]: Utilization of the nurse advice line Baseline: 0 (2/13) Goal: 400 patient calls to the line Data Source: Call Center Logs Milestone 3 Estimated Incentive Payment: $249,079	**Milestone 4** [I-13]: Improvement: Increase in the number of patients that accessed the nurse advice line Metric 1 [I-13.1]: Utilization of the nurse advice line Baseline: 0 (2/13) Goal: 600 patient calls to the line Data Source: Call Center Logs Milestone 4 Estimated Incentive Payment: $213,404
Year 2 Estimated Milestone Bundle Amount: $212,686	Year 3 Estimated Milestone Bundle Amount: $246,531	Year 4 Estimated Milestone Bundle Amount: $249,079	Year 5 Estimated Milestone Bundle Amount: $213,404
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $921,700			

Project Option: 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics or the expansion of dental clinic hours.
Performing Provider: City of Lubbock Health Department/135103304.1.1
Unique Project ID: 135103304.1.1

PROVIDER: The City of Lubbock, Texas is currently home to over 229,000 residents. The City of Lubbock Health Department's mission is to protect the health, safety and welfare of citizens through: 1. Preventing epidemics and the spread of disease; 2. Educating and empowering people to adopt health and responsible behaviors; 3. Promoting the quality and accessibility of health services; and 4. Developing new insights and innovative solutions to health problems.

INTERVENTIONS: The City of Lubbock Health Department will expand dental services, through the establishment of a new dental clinic.

NEED FOR THE PROJECT: The City of Lubbock selected this project because it directly addresses Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* The City of Lubbock does not currently operate a dental clinic; therefore, this will be a new endeavor.

TARGET POPULATION: The target population for this project includes people who don't historically have access to or avail themselves of dental care: people with mental illness, substance abuse issues, intellectual disabilities, people who are homeless, people struggling with the challenges of aging, veterans, people living in poverty, etc. Estimates are that 95% of the people served in this new clinic will be Medicaid funded or indigent.

CATEGORY 1 EXPECTED PATIENT BENEFITS: During DY3 the City of Lubbock will hire and train staff, develop all operational protocols and clinical guidelines and develop a baseline from which to calculate system improvements. The City of Lubbock hopes to provide at least 600 office visits during DY4 and to provide at least 750 office visits in DY5. Conceivably, over 350 people per year could be impacted by this project. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5.

CATEGORY 3 OUTCOMES: (IT – 7.7)The goal of this project is to decrease the number of older adults 65 years or older with urgent dental care needs by 10% from baseline in DY4 and 15% from baseline in DY5.

Project Option: 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics or the expansion of dental clinic hours.
Performing Provider: City of Lubbock Health Department/135103304.1.1
Unique Project ID: 135103304.1.1

Project Description:

Dental health is a key component of overall health. Oral disease can lead to poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes and cardiovascular disease; and a diminished quality of life and life expectancy. Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding and enhancing oral health services will improve health outcomes.

The Texas Dental Association (TDA) looked carefully at the economic, medical and social consequences of untreated oral disease in Texas. It reviewed the current systems of oral health care delivery, assessed payment structures, and studied the oral health status of Texans in general and analyzed the oral health disparities that exist in the state. Then TDA made specific and practical policy recommendations to expand access to oral health care in Texas, including: identifying a "dental home" for every citizen; creating new programs to encourage general dentists and specialists to practice in underserved areas and to treat underserved populations; developing a comprehensive oral health public awareness and education campaign; and expanding access to oral health services for older citizens.

This project focuses upon all of these state priorities by establishing a new dental clinic, targeting people who don't historically have access to or avail themselves of dental care: people with mental illness, substance abuse issues, intellectual disabilities, people who are homeless, people struggling with the challenges of aging, veterans, people living in poverty, etc. The City of Lubbock Health Department (City of Lubbock) does not have adequate resources to meet the demand for dental services in Lubbock, especially for populations with special needs. This project sets forth collaboration with the Local Mental Health Authority (StarCare Specialty Health System "StarCare") and a Federally Qualified Health Center (the Texas Tech School of Nursing's Federally Qualified Health Center, The Larry Combest Center for Health and Wellness "Combest") to obtain synergy, economies of scale and to increase access

for preventative dental visits impacting the severity of going to the dentist as a last resort. This project will help divert patients from more expensive, less effective treatment of extreme dental procedures.

In the first stage of this project, the City of Lubbock will partner with StarCare and Combest to engage a Lubbock Oral Health Project Coordinator to conduct a city-wide needs assessment related to citizens of all ages, to perform a gap analysis and to develop a dental coalition of all providers of dental services to people with low income. In addition, the coalition will develop a Lubbock Oral Health Plan and begin implementation of the Lubbock Oral Health Program. Next, the City of Lubbock, StarCare and Combest will partner to open a new dental clinic, to include the development of policies and procedures and hiring and training staff. The initial plan is to co-locate with a new integrated physical and behavioral health clinic in StarCare's Psychiatric Emergency Service Center in order to improve access to marginalized populations. The City of Lubbock hopes to provide at least 600 office visits during DY4 and to provide at least 750 office visits in DY5. Conceivably, over 350 people per year could be impacted by this project. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5.

Goal of Project: The primary goals of this project are to: close gaps/disparities in access to dental care services and to enhance the quality of dental care provided.

Challenges: Challenges associated with the successful implementation of this project are: lack of qualified dental providers, patient transportation and low oral health literacy. The City of Lubbock will work with its project partners to develop and implement a comprehensive provider recruitment effort and public information campaign. The dental clinic will likely provide bus passes to patients to help address issues related to transportation.

5-Year Expected Outcome for Performing Provider and Patients: Performing Provider Perspective – improved healthcare infrastructure that better serves the Medicaid-funded and uninsured residents of our counties; coordinated care delivery system; improved efficiency and cost growth containment.

- Patient Perspective – high quality, patient-centered care; improved access to coordinated healthcare; improved health outcomes.

Relationship to Regional Goals: Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The resulting document ranked the needs in tiers, according to the availability of evidence documenting each need. Tier one included the two (2) most pressing needs in RHP 12: 1) a severe lack of primary care access including provider shortages, financial barriers, wait times, and length of time to get an appointment; and 2) a lack of mental health services including lack of available appointments, insurance coverage, and emergency room usage for mental health issues. Tier two identified other priority issues as: 1) uninsured and underinsured; 2) high incidence of obesity, diabetes, and heart disease; 3) need for specialty care; and 4) need for cancer screenings; and 5) insufficient maternal and prenatal care. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement.

This project is directly related to the Region 12 goals of increased access to care and increased prevention and early detection activities. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.

Starting Point/Baseline: The City of Lubbock does not currently operate a dental clinic; therefore, the starting point/baseline for the number of people to be assisted is zero.

Reason/Rationale for Selecting Measure: *Poor oral health affects more than just the mouth. It can seriously compromise a person's general health, quality of life and life expectancy. Oral diseases can and do lead to systemic problems — damaging other parts of the body and resulting in the need for expensive emergency department visits, hospital stays and medications. The consequences of poor oral health, however, go far beyond damaging medical effects. Oral disease can also wreak economic havoc — keeping children out of school and adults home from work — not to mention lower productivity of workers in pain. Untreated oral diseases can also drive up health care costs in general. The good news is that with proper oral health care, both at home and in professional settings, many of the negative consequences associated with poor oral health can be prevented.*[1]

[1] http://www.buildingbetteroralhealth.org/media/TDA_full_report.pdf

The number of emergency-room visits for patients seeking dental treatment has increased, mostly because of problems that could have been prevented with regular dental visits, according to the Pew Center on the States. Most cases are in rural areas, which have a shortage of dentists. Nationwide, the number of ER dental visits increased 16 percent from 2006 to 2009, and the center suggests the trend is continuing. Visiting the ER for dental treatment can be 10 times more expensive than preventive care. Many visits involve the same patients seeking more care because emergency rooms aren't staffed by dentists. Doctors can offer pain relief, but not much more, and many patients can't afford follow-up treatment or can't find a dentist. "Emergency rooms are really the canary in the coal mine. If people are showing up in the ER for dental care, then we've got big holes in the delivery of care," said Shelly Gehshan, director of Pew's child-dentistry campaign. "It's just like pouring money down a hole." The Center analyzed information from 24 states, the Federal Agency for Healthcare Research and Quality and dental care studies. It found that in 2009, 56 percent of children with Medicaid didn't receive dental care, ER visits for dental care increased by almost 60 percent in South Carolina, and there were 55,000 dental-related ER visits in Tennessee hospitals. Part of the problem is that few dentists participate in Medicaid programs, The Associated Press reports. The center is working with states to develop dental hygienists training programs and train non-dentists to treat cavities and other uncomplicated procedures. More than 830,000 visits to emergency rooms nationwide in 2009 were for preventable dental problems. Dental disease is the No. 1 chronic childhood disease, sending more children in search of medical treatment than asthma. In a nation obsessed with high-tech medicine, people are not getting preventive care for something as simple as tooth decay. [2]

The following Project Option and Project Components were selected because they directly address Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.*

Project Option 1.8: Increase and expand services by increasing clinics, clinic hours, using satellite mobile clinics with an affiliated fixed-site dental clinic location, school-based/school-linked health centers or other approaches to increase oral health services to underserved populations. Project Component: 1.8.6 Establish a new dental clinic.

The City of Lubbock will conduct Continuous Quality Improvement (CQI) activities using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population and identifying key challenges associated with expansion of the project, including

[2] http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/A%20Costly%20Dental%20Destination(1).pdf

special considerations for safety-net populations. Our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Unique Community Need ID#: CN13 There is a shortage of dental services and CN3 Poor insurance support or uninsured.

Milestones & Metrics: The milestones and metrics (1.8.6 – P-4, 4.1; P-10, 10.1; and I-14, 14.1) selected for this project directly address CN#13&3 outlined in the Region 12 Community Needs Assessment.

Related Category 3 Outcome Measure: OD-7 Oral Health; IT-7.7 Urgent Dental Care Needs in Older Adults: Proportion of older adults aged 65 and older with urgent dental care needs (standalone measure)

Reason/Rationale for Selection: According to the Region 12 Community Needs Assessment, there is a shortage of dental services and a high prevalence of people with poor insurance support or who are uninsured. According to the TDA, services for older Texans is a priority.

Explanation of how focusing on the outcomes will help improve the health of low-income populations: Establishment of a new dental clinic focusing services upon people who are under- or uninsured will directly help improve the health of low-income populations.

Relationship to Other Projects: This project relates to the City of Lubbock's Pass 2 project (135103304.1. 2 – expand access/hours in dental clinic) in that it is the foundation project that opens a new dental clinic. These projects are all related in that they are aimed to increasing access to needed health care in the most appropriate setting.

Relationship to Other Performing Providers' Projects in RHP & Plan for Learning Collaborative: This project relates to StarCare's Pass 1 and Pass 2 projects (084897001.1.1 and 084897001.1.2) - to open a Psychiatric Emergency Service Center and adolescent crisis respite unit – in that this clinic will be housed within the same facility. Our RHP will encourage participation by all our partners in a "learning collaborative" that will meet annually to discuss local disparities in care and the ways they have successfully gathered

relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects. **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure people receive coordinated, timely and site-appropriate healthcare services. The City of Lubbock hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	**5**
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. The following Project Option and Project Components were selected because they directly address Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* The lack of available appointments for people without money or insurance, results in the need to use emergency rooms for initial contact.	**5**
Project Scope/Size Scale: 1 to 5 5 Greatest	The City of Lubbock hopes to provide at least 600 office visits during DY4 and to provide at least 750 office visits in DY5. Conceivably, over 350 people per year could be impacted by this project. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	**4**
Project Investment Scale: 1 to 5 5 Greatest	The City of Lubbock's investment in this project will be fairly significant. Staffing will include a Program Director, Dentist(s), Licensed Hygienists, Dentals Technicians, office personnel, etc. (Some administrative staff will be shared with StarCare and Combest in order to obtain economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc. As one might imagine, dental equipment can be very expensive.	**4**

135103304.1.1	1.8.6	n/a	The expansion of existing dental clinics, the establishment of additional dental clinics or the expansion of dental clinic hours.
City of Lubbock Health Department		**135103304**	
Related Category 3 Outcome Measure(s):	**135103304.3.1**	**IT-7.7**	**Urgent Dental Care Need in Older Adults: Proportion of older adults aged 65 and older with urgent dental care needs**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-10]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers shall identify and agree upon several improvement (simple initiatives that all providers can do to "raise the floor" for performance.) Each participating provider should publicly commit to implementing these improvements. **Metric(s):** [P-10.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	**Milestone 2:** [P-10]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers shall identify and agree upon several improvement (simple initiatives that all providers can do to "raise the floor" for performance.) Each participating provider should publicly commit to implementing these improvements. **Metric(s):** [P-10.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Participate in face-to-face meetings **Data Source:** Documentation of semi-annual meetings, including meeting agendas, slides from presentations, and/or meeting notes.	**Milestone 4:** [P-4]: Establish additional/expand existing/relocate dental care clinics or space. **Metric(s):** [P-4.1] Number of additional clinics, expanded space, or existing available space used to capacity. **Baseline/Goal:** Add 1 new clinic **Data Source:** Tax ID# **Milestone 4 Estimated Incentive Payment:** $760,530 **Milestone 5:** [P-3] Increase Interdisciplinary (IDT) training and education for dental and other health care providers to promote an ID Team approach to addressing oral health. **Metric(s):** [P3.1] City of Lubbock will hold quarterly (4/year) grand rounds, in-service	**Milestone 6:** [I-14] Increase number of special population members that access dental services **Metric(s):** [I-14.1] 15% increase from baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services. **Baseline/Goal:** 10% increase over baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services. **Data Source:** Claims, encounter and clinical record data **Milestone 6 Estimated Incentive Payment:** $1,102,218 **Milestone 7:** [P-3] Increase Interdisciplinary (IDT)

Baseline/Goal: Participate in face-to-face meetings **Data Source:** Documentation of semi-annual meetings, including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 1 Estimated Incentive Payment:** $1,942,214	**Milestone 2 Estimated Incentive Payment:** $1,066,396 **Milestone 3:** [P-3] Increase Interdisciplinary (IDT) training and education for dental and other health care providers to promote an ID Team approach to addressing oral health. **Metric(s):** [P3.1] City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Goal:** City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Data Source:** Attendance rosters, power point presentations, sign in sheets, etc. **Milestone 3 Estimated Incentive Payment:** $1,066,395	trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Goal:** City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Data Source:** Attendance rosters, power point presentations, sign in sheets, etc. **Milestone 5 Estimated Incentive Payment:** $760,530 **Milestone 6:** [I-14] Increase number of special population members that access dental services **Metric(s):** [I-14.1] 10% increase over baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services. **Goal:** 10% increase over baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services.	training and education for dental and other health care providers to promote an ID Team approach to addressing oral health. **Metric(s):** [P3.1] City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Goal:** City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Data Source:** Attendance rosters, power point presentations, sign in sheets, etc. **Milestone 7 Estimated Incentive Payment:** $1,102,217

		Data Source: Claims, encounter and clinical record data **Milestone 6 Estimated Incentive Payment:** $760,530	
DY 2 Estimated Milestone Bundle Amount: $1,942,214	**DY 3 Estimated Milestone Bundle Amount:** $2,132,791	**DY4 Estimated Milestone Bundle Amount:** $2,281,590	**DY5 Estimated Milestone Bundle Amount:** $2,204,435
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $8,561,029			

Project Option: 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics or the expansion of dental clinic hours. **Performing Provider:** City of Lubbock Health Department/135103304
Unique Project ID: 135103304.1.2 – **"PASS 2"**

PROVIDER: The City of Lubbock, Texas is currently home to over 229,000 residents. The City of Lubbock Health Department's mission is to protect the health, safety and welfare of citizens through: 1. Preventing epidemics and the spread of disease; 2. Educating and empowering people to adopt health and responsible behaviors; 3. Promoting the quality and accessibility of health services; and 4. Developing new insights and innovative solutions to health problems.

INTERVENTIONSThe City of Lubbock Health Department will expand dental services, through the establishment of a new dental clinic.

NEED FOR THE PROJECT: The City of Lubbock selected this project because it directly addresses Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* The City of Lubbock does not currently operate a dental clinic; therefore, this will be a new endeavor.

TARGET POPULATION: The target population for this project includes people who don't historically have access to or avail themselves of dental care: people with mental illness, substance abuse issues, intellectual disabilities, people who are homeless, people struggling with the challenges of aging, veterans, people living in poverty, etc. Estimates are that 95% of the people served in this new clinic will be Medicaid funded or indigent.

CATEGORY 1 EXPECTED PATIENT BENEFITS: During DY3 the City of Lubbock will hire and train staff, develop all operational protocols and clinical guidelines and develop a baseline from which to calculate system improvements. With Pass 1 funding, the City of Lubbock plans to provide at least 600 office visits in DY4 and to provide at least 750 office visits in DY5, serving 350 people per year. Pass 2 funding will allow the City of Lubbock to provide an additional 250 office visits each year in DY4 and DY5, with capacity to serve 147 more people each year. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5.

CATEGORY 3 OUTCOMES: (IT – 7.7) The goal of this project is to decrease of older adults 65 years or olderwith urgent dental care needsby 10% from baseline in DY4 and 15% from baseline in DY5.

Project Option: 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics or the expansion of dental clinic hours.
Performing Provider: City of Lubbock Health Department/135103304
Unique Project ID: 135103304.1.2 - **"PASS 2"**

Project Description: During Pass 2, the City of Lubbock will expand its Pass 1 project (which was to establish a new dental clinic) in two (2) ways: 1. Serve more people than possible with Pass 1 funding alone and 2. Expand dental clinic hours from those anticipated with Pass 1 funding.

Dental health is a key component of overall health. Oral disease can lead to poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes and cardiovascular disease; and a diminished quality of life and life expectancy. Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding and enhancing oral health services will improve health outcomes.

The Texas Dental Association (TDA) looked carefully at the economic, medical and social consequences of untreated oral disease in Texas. It reviewed the current systems of oral health care delivery, assessed payment structures, and studied the oral health status of Texans in general and analyzed the oral health disparities that exist in the state. Then TDA made specific and practical policy recommendations to expand access to oral health care in Texas, including: identifying a "dental home" for every citizen; creating new programs to encourage general dentists and specialists to practice in underserved areas and to treat underserved populations; developing a comprehensive oral health public awareness and education campaign; and expanding access to oral health services for older citizens.

This project (in combination with the City of Lubbock's Pass 1 project) focuses upon all of these state priorities by establishing a new dental clinic, targeting people who don't historically have access to or avail themselves of dental care: people with mental illness, substance abuse issues, intellectual disabilities, people who are homeless, people struggling with the challenges of aging, veterans, people living in poverty, etc. The City of Lubbock Health Department (City of Lubbock) does not have adequate resources to meet the demand for dental services in Lubbock, especially for populations with special needs. This project sets forth collaboration with

the Local Mental Health Authority (StarCare Specialty Health System "StarCare") and a Federally Qualified Health Center (the Texas Tech School of Nursing's Federally Qualified Health Center, The Larry Combest Center for Health and Wellness "Combest") to obtain synergy, economies of scale and to increase access for preventative dental visits impacting the severity of going to the dentist as a last resort. This project will help divert patients from more expensive, less effective treatment of extreme dental procedures.

The City of Lubbock plans to partner with StarCare and Combest to engage a Lubbock Oral Health Project Coordinator to conduct a city-wide needs assessment related to citizens of all ages, to perform a gap analysis and to develop a dental coalition of all providers of dental services to people with low income. In addition, the coalition will develop a Lubbock Oral Health Plan and begin implementation of the Lubbock Oral Health Program. Next, the City of Lubbock, StarCare and Combest will partner to open a new dental clinic, to include the development of policies and procedures and hiring and training staff. The initial plan is to co-locate with a new integrated physical and behavioral health clinic in StarCare's Psychiatric Emergency Service Center in order to improve access to marginalized populations. With Pass 1 funding, the City of Lubbock plans to provide at least 600 office visits in DY4 and to provide at least 750 office visits in DY5, serving 350 people per year. Pass 2 funding will allow the City of Lubbock to provide an additional 250 office visits each year in DY4 and DY5, with capacity to serve 147 more people each year. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5.

Goal of Project: The primary goals of this project are to: close gaps/disparities in access to dental care services and to enhance the quality of dental care provided.

Challenges: Challenges associated with the successful implementation of this project are: lack of qualified dental providers, patient transportation and low oral health literacy. The City of Lubbock will work with its project partners to develop and implement a comprehensive provider recruitment effort and public information campaign. The dental clinic will likely provide bus passes to patients to help address issues related to transportation.

5-Year Expected Outcome for Performing Provider and Patients: Performing Provider Perspective – improved healthcare infrastructure that better serves the Medicaid-funded and uninsured residents of our counties; coordinated care delivery system; improved efficiency and cost growth containment.

- Patient Perspective – high quality, patient-centered care; improved access to coordinated healthcare; improved health outcomes.

Relationship to Regional Goals: Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The resulting document ranked the needs in tiers, according to the availability of evidence documenting each need. Tier one included the two (2) most pressing needs in RHP 12: 1) a severe lack of primary care access including provider shortages, financial barriers, wait times, and length of time to get an appointment; and 2) a lack of mental health services including lack of available appointments, insurance coverage, and emergency room usage for mental health issues. Tier two identified other priority issues as: 1) uninsured and underinsured; 2) high incidence of obesity, diabetes, and heart disease; 3) need for specialty care; and 4) need for cancer screenings; and 5) insufficient maternal and prenatal care. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement.

This project is directly related to the Region 12 goals of increased access to care and increased prevention and early detection activities. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.

Starting Point/Baseline: The City of Lubbock does not currently operate a dental clinic; therefore, the starting point/baseline for the number of people to be assisted is zero.

Reason/Rationale for Selecting Measure: *Poor oral health affects more than just the mouth. It can seriously compromise a person's general health, quality of life and life expectancy. Oral diseases can and do lead to systemic problems — damaging other parts of the body and resulting in the need for expensive emergency department visits, hospital stays and medications. The consequences of poor oral health, however, go far beyond damaging medical effects. Oral disease can also wreak economic havoc — keeping children out of school and adults home from work — not to mention lower productivity of workers in pain. Untreated oral diseases can also drive up health care costs in general. The good news is that with proper oral health care, both at home and in professional settings, many of the negative consequences associated with poor oral health can be prevented.*[3]

[3] http://www.buildingbetteroralhealth.org/media/TDA_full_report.pdf

The number of emergency-room visits for patients seeking dental treatment has increased, mostly because of problems that could have been prevented with regular dental visits, according to the Pew Center on the States. Most cases are in rural areas, which have a shortage of dentists. Nationwide, the number of ER dental visits increased 16 percent from 2006 to 2009, and the center suggests the trend is continuing. Visiting the ER for dental treatment can be 10 times more expensive than preventive care. Many visits involve the same patients seeking more care because emergency rooms aren't staffed by dentists. Doctors can offer pain relief, but not much more, and many patients can't afford follow-up treatment or can't find a dentist. "Emergency rooms are really the canary in the coal mine. If people are showing up in the ER for dental care, then we've got big holes in the delivery of care," said Shelly Gehshan, director of Pew's child-dentistry campaign. "It's just like pouring money down a hole." The Center analyzed information from 24 states, the Federal Agency for Healthcare Research and Quality and dental care studies. It found that in 2009, 56 percent of children with Medicaid didn't receive dental care, ER visits for dental care increased by almost 60 percent in South Carolina, and there were 55,000 dental-related ER visits in Tennessee hospitals. Part of the problem is that few dentists participate in Medicaid programs, The Associated Press reports. The center is working with states to develop dental hygienists training programs and train non-dentists to treat cavities and other uncomplicated procedures. More than 830,000 visits to emergency rooms nationwide in 2009 were for preventable dental problems. Dental disease is the No. 1 chronic childhood disease, sending more children in search of medical treatment than asthma. In a nation obsessed with high-tech medicine, people are not getting preventive care for something as simple as tooth decay. [4]

The following Project Option and Project Components were selected because they directly address Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.*

Project Option 1.8: Increase and expand services by increasing clinics, clinic hours, using satellite mobile clinics with an affiliated fixed-site dental clinic location, school-based/school-linked health centers or other approaches to increase oral health services to underserved populations. Project Component: 1.8.6 Expansion of dental clinic hours

The City of Lubbock will conduct Continuous Quality Improvement (CQI) activities using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population and identifying key challenges associated with expansion of the project, including

[4] http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/A%20Costly%20Dental%20Destination(1).pdf

special considerations for safety-net populations. Our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Unique Community Need ID#: CN13 There is a shortage of dental services and CN3 Poor insurance support or uninsured.

Milestones & Metrics: The milestones and metrics (1.8.6 – P-4, 4.1; P-10, 10.1; and I-14, 14.1) selected for this project directly address CN#13&3 outlined in the Region 12 Community Needs Assessment.

Related Category 3 Outcome Measure: OD-7 Oral Health; IT-7.7 Urgent Dental Care Needs in Older Adults: Proportion of older adults aged 65 and older with urgent dental care needs (standalone measure)

Reason/Rationale for Selection: According to the Region 12 Community Needs Assessment, there is a shortage of dental services and a high prevalence of people with poor insurance support or who are uninsured. According to the TDA, services for older Texans is a priority.

Explanation of how focusing on the outcomes will help improve the health of low-income populations: Establishment of a new dental clinic focusing services upon people who are under- or uninsured will directly help improve the health of low-income populations.

Relationship to Other Projects: This project relates to the City of Lubbock's Pass 1 project (135103304.1. 1 – expand access/hours in dental clinic) in that it allows the new clinic to be open longer hours than possible with only Pass 1 funding. These projects are all related in that they are aimed to increasing access to needed health care in the most appropriate setting.
Relationship to Other Performing Providers' Projects in RHP & Plan for Learning Collaborative: This project relates to StarCare's Pass 1 and Pass 2 projects (084897001.1.1 and 084897001.1.2) - to open a Psychiatric Emergency Service Center and adolescent crisis respite unit – in that this clinic will be housed within the same facility. Our RHP will encourage participation by all our partners in a "learning collaborative" that will meet annually to discuss local disparities in care and the ways they have successfully gathered

relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure people receive coordinated, timely and site-appropriate healthcare services. The City of Lubbock hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces un- necessary or duplicative services and builds on the accomplishments of our existing healthcare system.	**5**
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. The following Project Option and Project Components were selected because they directly address Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* The lack of available appointments for people without money or insurance, results in the need to use emergency rooms for initial contact.	**5**
Project Scope/Size Scale: 1 to 5 5 Greatest	With Pass 1 funding, the City of Lubbock plans to provide at least 600 office visits in DY4 and to provide at least 750 office visits in DY5, serving 350 people per year. Pass 2 funding will allow the City of Lubbock to provide an additional 250 office visits each year in DY4 and DY5, with capacity to serve 147 more people each year. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	**4**
Project Investment Scale: 1 to 5 5 Greatest	The City of Lubbock's investment in this project will be fairly significant. Staffing will include a Program Director, Dentist(s), Licensed Hygienists, Dentals Technicians, office personnel, etc. (Some administrative staff will be shared with StarCare and Combest in order to obtain economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc. As one might imagine, dental equipment can be very expensive.	**4**

135103304.1.2	1.8.6	n/a	The expansion of existing dental clinics, the establishment of additional dental clinics or the expansion of dental clinic hours.
City of Lubbock Health Department		**135103304**	
Related Category 3 Outcome Measure(s):	**135103304.3.2**	**IT-7.7**	**Urgent Dental Care Need in Older Adults: Proportion of older adults aged 65 and older with urgent dental care needs**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-10]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers shall identify and agree upon several improvement (simple initiatives that all providers can do to "raise the floor" for performance.) Each participating provider should publicly commit to implementing these improvements. **Metric(s):** [P-10.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Participate in face-to-face meetings **Data Source:** Documentation of semi-annual meetings, including meeting agendas, slides from	**Milestone 2:** [P-10]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers shall identify and agree upon several improvement (simple initiatives that all providers can do to "raise the floor" for performance.) Each participating provider should publicly commit to implementing these improvements. **Metric(s):** [P-10.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Participate in face-to-face meetings **Data Source:** Documentation of semi-annual meetings, including meeting agendas, slides from presentations, and/or meeting	**Milestone 4:** [P-4]: Establish additional/expand existing/relocate dental care clinics or space. **Metric(s):** [P-4.1] Number of additional clinics, expanded space, or existing available space used to capacity. **Baseline/Goal:** Add 1 new clinic **Data Source:** Tax ID# **Milestone 4 Estimated Incentive Payment:** $106,001 **Milestone 5:** [P-3] Increase Interdisciplinary (IDT) training and education for dental and other health care providers to promote an ID Team approach to addressing oral health. **Metric(s):** [P3.1] City of Lubbock will hold quarterly (4/year) grand rounds, in-service	**Milestone 6:** [I-14] Increase number of special population members that access dental services **Metric(s):** [I-14.1] 15% increase from baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services. **Baseline/Goal:** 10% increase over baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services. **Data Source:** Claims, encounter and clinical record data **Milestone 6 Estimated Incentive Payment:** $147,698 **Milestone 7:** [P-3] Increase Interdisciplinary (IDT)

presentations, and/or meeting notes. **Milestone 1 Estimated Incentive Payment:** $297,150	notes. **Milestone 2 Estimated Incentive Payment:** $156,186 **<u>Milestone 3:</u>** [P-3] Increase Interdisciplinary (IDT) training and education for dental and other health care providers to promote an ID Team approach to addressing oral health. **Metric(s):** [P3.1] City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Goal:** City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Data Source:** Attendance rosters, power point presentations, sign in sheets, etc.	trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Goal:** City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Data Source:** Attendance rosters, power point presentations, sign in sheets, etc. **Milestone 5 Estimated Incentive Payment:** $106,000 **<u>Milestone 6:</u>** [I-14] Increase number of special population members that access dental services **Metric(s):** [I-14.1] 10% increase over baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services.	training and education for dental and other health care providers to promote an ID Team approach to addressing oral health. **Metric(s):** [P3.1] City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Goal:** City of Lubbock will hold quarterly (4/year) grand rounds, in-service trainings and continuing education that focus on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease and pregnancy. **Data Source:** Attendance rosters, power point presentations, sign in sheets, etc. **Milestone 7 Estimated Incentive Payment:** $147,698

	Milestone 3 Estimated Incentive Payment: $156,185	**Goal:** 10% increase over baseline in the number of children, special needs patients, pregnant women and/or the elderly accessing dental services. **Data Source:** Claims, encounter and clinical record data **Milestone 6 Estimated Incentive Payment:** $106,000	
DY 2 Estimated Milestone Bundle Amount: $297,150	**DY 3 Estimated Milestone Bundle Amount:** $312,371	**DY4 Estimated Milestone Bundle Amount:** $318,001	**DY5 Estimated Milestone Bundle Amount:** $295,396
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,222,918			

Project Option: 1.1.2 Expand Existing Primary Care Capacity
Performing Provider: Cogdell Memorial Hospital/136330107
RHP Unique Identification Number: 136330107.1.1
Project Components: 1.1.2.a-c

Provider: Cogdell Memorial Hospital is a 49-bed sole community hospital serving a 30 square mile radius and a population base of almost 16,000.

Interventions: This project will implement a walk-in clinic as well as expand primary care clinic space and providers.

Need for Project: Currently our community only has the Cogdell Family Clinic for primary care which sees patients Monday – Friday 8:30-5:30. The need is more after hour's coverage as well as a need for more primary care providers who do FP and OB.

Target Population: Our target population is those patients who cannot get an appointment within 24 hours and those who do not have insurance. We believe we will be able to increase our annual visits by 1,500 to get patients in the same day. Currently, our clinic sees about 30% Medicare, 20% Medicaid and Medicaid Managed Care, 33% Managed Care, 15% self-pay and 2% other. Our clinic not only handles primary care, but OB and of the 215 deliveries we do a year approximately 85% of them is Medicaid.

Category 1 or 2 expected patient benefits: Our estimated impact of this project will be to increase primary care visits by over 200 a month in DY 4 and over 250 a month in DY5.

Category 3 Outcomes: – the low income population base for our community is approximately 35%, of which 15% are uninsured and 20% are on Medicaid/Medicaid Managed Care, by increasing the primary care capacity with a walk in clinic and adding more space and providers, CMH will be able to treat more patients timely and get patients the care needed. This will help with better follow up as on these patients when they do get admitted by having case management follow up with these patients after discharge to ensure they have gotten in with their primary care provider to ensure they are staying on their treatment.

Project Option: 1.1.2 Expand Existing Primary Care Capacity

Performing Provider: Cogdell Memorial Hospital/136330107

RHP Unique Identification Number: 136330107.1.1

Project Components: 1.1.2.a-c

Project Description: We purpose to develop a process to expand primary care services with short term and long term goals in mind. To accomplish this the plan, a "walk-in" clinic will be added in order to decrease non-emergent care seen in our emergency department; work with our rural health clinic providers(family practice/OB and mid-level providers) and staff to work with patients to be seen in the clinic within an appropriate time frame; a new clinic will be built on the hospital grounds to bring all services together in order for care to be more efficient and timely; and recruitment of physicians and/or other providers (ie, PA's, Nurse Practitioners, etc). This will allow us to increase our annual visits by 1,500 and get those who are needing an appointment in on the same day.

In Scurry County we face several challenges with patients needing to be seen timely; individuals with a chronic condition do not get the care they need on an ongoing basis and therefore their condition(s) become acute causing them to be seen in the Emergency Department due to this is their only option; and delays in appointment scheduling and long waiting times have a significant negative impact on patients satisfaction 1and provider care, discouraging patients from using healthcare proactively. As a public hospital and low operating margin, we have a need access capital to expand.

The implementation of this project will address the challenges as listed above. Expansion of primary care is the first step in order to give care to the patient(s) in need and to keep patients out of the Emergency Department with non-emergent healthcare issues. By the implementation of the "walk-in" clinic and improving access to care in the primary care setting will also increase the opportunities to prevent disease and treat in a timely manner to prevent patients from becoming extremely ill with chronic conditions and other conditions out of the ED and hospital. The hospital will involve case management to assist with the process with discharged patients to educate patients and following up with patients regarding care after they are dismissed from the hospital (ie, follow up appointments, medication administration, etc) to also eliminate possible readmissions.

Our five (5) year expected outcome for this project is to substantially improve Cogdell Memorial Hospital and Cogdell Family Clinic (Rural Health Clinic) primary care capacity, as evidenced by 20% or more increase in primary care encounters and reduction of non-emergent care seen in the ED and chronic healthcare conditions.

This project is related to the regional goals by improving the capacity of primary care, reduce readmissions, patients having to be transferred to tertiary care facilities by patients being seen in the appropriate setting in a timely time frame. Also, the improvement will help CMH better serve the low income and uninsured.

Starting Point/Baseline: Our primary service is approximately 16,000 in the Scurry County region of which the hospital sees approximately 8400 patient in the ED each year and of this number approximately 30% or more is non-emergent, and utilizing the ED due to lack of primary care capacity. Cogdell Family Clinic provided approximately 20,000 patients in 2011. We have recently lost two (2) more providers adding to our crisis of needed providers. Due to this additional loss we have noted more patient's travelling a 30 to 90 mile range for primary care or not receiving care at all. The hospital and clinic have noted a decrease in other services (ie., lab, radiology, etc) with the decrease of primary providers. The short term strategic goal for this is diligent primary care provider recruitment to resolve this crisis. The long term strategic goal is for the hospital is to recruit an additional three (3) primary care providers over the next five (5) years and the goal with full capacity of primary providers the clinic will be able to grow approximately 20% to 30%. Another long term strategic goal is to build a new clinic with a new design in order to assist with recruitment and retention efforts. Currently, the clinic is seeing 4-5 day wait time for patients to get into see a physician as well as with the shortage in providers, having to turn away patients who are needing to be treated. This causes an increase in ER utilization, which the hospital has seen over the last couple of months going from an average of 700 a month to over 750 a month as well as some patients going elsewhere to find primary care services. We currently have approximately 1,500 patients who have been diagnosed with uncontrolled hypertension and more who have not out of our 16,000 patients in our service area. This project will allow us to work on getting more patients to come in and get tested and get on a plan to help get those who hypertension is uncontrolled back in line. Also, we below we will be able to increase our annual visits by 1,500 in order to get patients in the same day.

Rationale: The project option chosen by CMH is very critical to its community and its ability to provide services need by the community. In project 1.1.2, CMH will meet the required components by a) expand the clinic space by building a new clinic with a walk-in clinic, b) it will increases its primary care service hours by hiring PAs to service the walk-in clinic and remain open for longer

hours in the evening and the weekend, and c) finally CMH will increase clinic staffing by hiring the 2 new PAs, 3 new FP/OB's over the next five years. With this project CMH will be addressing a critical need CN.1, where CMH will address severe primary carfe shortage, CMH is in HPSA, decrease wait times and be developing walk-in clinic it will give patients a choice especially those who lack insurance and have lack of access to care. In doing this, CMH will show process milestones of P-1, Establish/Expand existing/relocate primary care clinic, P-4, Expand the hours of the primary clinic where they are currently serving patients from 9-5 M-F, and P-5, Train/Hire additional primary care providers and staff thru hiring more PAs and FP/OBs. CMH will have Improvement Milestones of I-10, Enhance patient access to primary care services by reducing days to third next available appointment, I-12.1 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services, I-15, Increase access to primary care capacity. In doing all of this, CMH will be better able to serve its population and help to ensure those patients with chronic conditions are seen timely and their needs addressed. CMH will be able to address new initiatives thru the development of a walk-in clinic process, recruitment of new physicians and PAs as well as provide better service to our patients by offering longer hours to be seen by a primary care provider. Also, with this project CMH will be able to significantly enhance existing initiatives, improved patient satisfaction and quality.

Related Category 3 Outcome Measure(s): CMH has chosen IT 1.7.

For IT 1.1 – the low income population base for our community is approximately 35%, of which 15% are uninsured and 20% are on Medicaid, by increasing the primary care capacity with a walk in clinic and adding more space and providers, CMH will be able to treat more patients timely and get patients the care needed. This will help with better follow up as on these patients when they do get admitted by having case management follow up with these patients after discharge to ensure they have gotten in with their primary care provider to ensure they are staying on their treatment. We currently have approximately 1,500 patients who have been diagnosed with uncontrolled hypertension and more who have not out of our 16,000 patients in our service area. This project will allow us to work on getting more patients to come in and get tested and get on a plan to help get those who hypertension is uncontrolled back in line.

Relationship to other Projects: This project will be closely related to project 2.3, Redesigning primary care. By building the clinic on site, patients will have the ability to get all of their services needed in one place and during the same clinic visit. By doing this, providers will be able to see patients more timely any issues the patient maybe experiencing will be addressed timely. Thru the redesign of the new clinic, this will help improve the patient flow and allow CMH to see more patients.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	In doing our project, CMH will be able to provide more timely care thru the addition of more providers, a walk-in clinic staffed by PA's which will be part of a new clinic designed to improve patient flow and reduce wait times. By doing all of this, CMH will be able to save money by treating patients more timely and more effectively thus reducing non-emergent ER visits and possible hospitalizations. This project will work got to category 3 project 1.1, Third next available appointment This project affects all patients, but it does give e the uninsured and low income a lot more opportunities to get in and see a primary care provider on a timely basis. The impact will be very significant to our community thru the increase in providers, better scheduling processes, and the walk-in clinic. There is very strong evidence what this project will accomplish is supported by literature and will help transform the way we do healthcare in our service area.	**4**
Addresses Community Need(s)	This project will address many community needs and issues. It will resolve the issue of getting into a primary care doctor, it will resolve the ER issues, the quality of care provided and the ability to get ancillary services when needed.	**5**
Project Scope/Size	The walk in clinic will allow anyone to come in and get treated along with the hospitals ability to set aside indigent dollars to take care of those who qualify for charity or indigent, much higher standards than Medicaid. Patient visits/encounters, thru this process CMH hopes to grow encounters by over 10% a year starting in year 3. Providers recruited/trained – 3 and possibly 2-3 Pas/NPS Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations - $2,400,000	**5**
Project Investment	Human resources – significant resources will be needed to cover the increase in providers, the walk in clinic. Not only providers, but nurses, billers, coders, housekeeping staff, maintenance, registration Equipment purchase and maintenance – Maintenance cost can grow extreme to keep everything up and going Legal and professional fees will be moderate in this process Time to implement will take several years to get all the providers on board, basically the life of the 5 year waiver Risk assessment – some risk, but rewards are more Organizational priorities – A top priority in the organization.	**5**

136330107.1.1	1.1.2	1.1.2 a, b, c	1.1 Expand Primary Care Capacity	
Cogdell Memorial Hospital			**136330107**	
Related Category 3 Outcome Measure(s):	**136330107.3.1**	**IT 1.7**	**Controlling High Blood Pressure**	
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)		DY 4 (10/1/2014-9/30/2015)	DY 5 (10/1/2015-9/30/2016)
Milestone 1: P-1 Establish additional/expand existing/relocate primary care clinics **P-1.1. Metric:** Number of additional clinics or expanded hours or space documentation of detailed expansion plans **Baseline/Goal:** Expand Space/clinic. Start construction of new clinic to be on hospital grounds completion 2014 **Data Source:** Construction plans and construction schedule **Milestone 1 Estimated Incentive Payment***:* $264,230 **Milestone 2: P-5** Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers **P-5.1. Metric:** Documentation of increased number of providers and staff and/or clinic sites.	**Milestone 3**: **P-5** Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers **P-5.1. Metric:** Documentation of increased number of providers and staff and/or clinic sites. **Baseline/Goal:** Add an additional provider, making a total of 8 primary care providers in clinic. **Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. **Milestone 3 Estimated Incentive Payment:** $654,082		**Milestone 4**: **I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services thru the education of non-emergent ER visits. Currently we have a service area of 16,000 with approximately 8,400 ER visits of which approximately 2,500 are non-emergent we would like to be seen in our primary care clinic each year. **I-12.1. Metric:** Documentation of increased number of visits demonstrates improvement over prior reporting period. a. Total number of visits for reporting period **Goal:** Increase primary care visits from an average of 2,000 a month in base year to 2,125 a month **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive**	**Milestone 5**: **I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **I-12.1. Metric:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period **Goal:** Increase primary care visits from 2,000 a month in base year to over 2,250 a month **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 5 Estimated Incentive Payment:** $584,705

136330107.1.1	**1.1.2**	**1.1.2 a, b, c**	**1.1 Expand Primary Care Capacity**	
Cogdell Memorial Hospital			**136330107**	
Related Category 3 Outcome Measure(s):	**136330107.3.1**	**IT 1.7**	**Controlling High Blood Pressure**	
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)		DY 4 (10/1/2014-9/30/2015)	DY 5 (10/1/2015-9/30/2016)
Baseline/Goal: Hire one new primary care provider. Go from 6 to 7 primary care providers. **Data Source:** Documentation of completion of all items described by the RHP plan for this measure. **Milestone 2 Estimated Incentive Payment:** $264,230			**Payment:** $664,547	
DY 2 Estimated Milestone Bundle Amount: $528,460	DY 3 Estimated Milestone Bundle Amount: $654,082		DY4 Estimated Milestone Bundle Amount: $664,547	DY5 Estimated Milestone Bundle Amount: $584,705
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,431,794				

Project Option: 1.10.1 Enhance improvement capacity within people

Performing Provider: Cogdell Memorial Hospital/136330107

RHP Unique Identification Number: 136330107.1.3 – "PASS 3B"

Project Components: 1.10.1.a-b

Provider: Cogdell Memorial Hospital is a 49-bed sole community hospital serving a 30 square mile radius and a population base of almost 16,000.

Interventions: This project will require Cogdell Memorial Hospital to develop and enhance its performance and quality improvement processes

Need for Project: As more and more requirements come down from the federal and state legislature, there is a need to improve our QAPI process and develop others which will help us meet these requirements as well as develop better processes for taking care of our patients.

Target Population: CMH has over 200 employees who will need to be educated and trained on how to improve processes. With CMH having over 20,000 clinic visits, 1,000 outpatient surgeries, 8,400 emergency room visits and over 1,500 patients in house each year, there is a need to improve our processed and our quality to ensure our patients get the best care. Of this population, 20% is Medicaid and Medicaid Managed Care and 15% is Self-pay. Currently, we have 1 person who oversees performance improvement and quality improvement and we will work towards getting at least 2-4 more who are trained to help educate the 200 plus staff we have who need trained. With the improved training we will be able to put processes in place to address CHF admission rate and address the approximate 1,500 patients with CHF and the related 100 admissions a year and reduce these by 10 a year thru our Category 3 project..

Category 1 or 2 expected patient benefits: Thru the increased quality reports in DY 4 and a quality dashboard in DY 5, all patients, including Medicaid and insured, will be getting the best quality possible.

Category 3 Outcomes: IT 2.1 CHF Admission Rate, by enhancing our performance improvement process, CMH should be able to reduce the CHF admission rate through treating more patients timely, following up on continued treatments to ensure patients are staying on their plan. The goal is to reduce CHF preventable Admissions a year by 10%.

Project Option: 1.10.1 Enhance improvement capacity within people

Performing Provider: Cogdell Memorial Hospital/136330107

RHP Unique Identification Number: 136330107.1.3 – "PASS 3B"

Project Components: 1.10.1.a-b

Project Description: CMH will develop its quality improvement and performance improvement program through education to hospital staff in all departments, not just clinical. Currently, we have 1 person who oversees our quality improvement process and thru this project we will work to have at least 2-4 more who will help develop and oversee along with training over 200 employees, and 8-10 physicians. We will use these train to create programs to help address CHF admission rates. We believe there are 1,500 patients in our service area with CHF and we hope to reduce the 100 admissions a year by 10 a year to begin with thru our Category 3 project.. The main reason for all departments is because if there is an issue in the business office, and we do not improve the processes then we still have provided unacceptable levels of patient customer service. Also, by expanding and redeveloping our process improvement and quality improvement programs, the hospital will be able to meet the needs of its patients, their families, our employees and physicians at the same time better serve our community. We will do this through a number of ways. One is getting an electronic reporting system to input all quality issues, add a process where employees, patients, physicians and visitors can feel free to make suggestions to help us improve our processes, and ensure each department is setting performance improvement measures and monitoring monthly and using PDSA to address any issues. There is even more of a need to improve our processes due to the changes coming in healthcare and the focus on quality and the various core measures. Also, in order to remain a viable small community hospital we will need to develop better processes so we can operate efficiently while providing the highest quality of care.

In Scurry County we face several challenges with patients needing to be seen timely; individuals with a chronic condition do not get the care they need on an ongoing basis and therefore their condition(s) become acute causing them to be seen in the Emergency Department due to this is their only option; thru the development of our process improvement teams we will be able to see patients more timely to ensure they are getting treatment needed as well as follow up with the patients to ensure they are staying on their prescribed treatment plan. In our population served we have approximately 2,500 patients who are on Medicare, but of these patients they make up approximately 30% or almost 20,000 of all of our inpatient and outpatients visits. This is typical of most Medicare patients who do have chronic conditions and who are in need of healthcare services on a regular basis. As a public hospital with low operating margins, we have a need to access capital to be able to ensure we are providing the latest technology

and expand as volumes dictate. By improving our processes and our quality will allow us access to this capital and the ability to keep up with the changes in technology and expand so we can be around for years to come.
The implementation of this project will address the challenges as listed above as well as address the challenges we will face through the upcoming changes to Medicare, Medicaid and Managed Care programs not just today but for years to come. By improving our process and our quality we will be able to lower healthcare costs and make it affordable to those on Medicaid and low income patients. By the implementation of various primary care strategies they will allow us to improve our patients' access to care in the primary care setting and will also increase the opportunities to prevent disease and treat in a timely manner to prevent patients from becoming extremely ill with chronic conditions. The hospital will involve case management to assist with the process with discharged patients to educate patients and following up with patients regarding care after they are dismissed from the hospital (ie, follow up appointments, medication administration, etc) to also eliminate possible readmissions. The only way we can do this will be for us to enhance our process improvement and reporting.
Our five (5) year expected outcome for this project is to substantially improve Cogdell Memorial Hospital and Cogdell Family Clinic through the development and improvement of our quality and performance improvement process.
This project is related to the regional goals by improving our internal processes as well as working with other hospitals in which we transfer patients we help to ensure improved patient care, patient flow and the overall help of our patients especially those the low income and uninsured.

Starting Point/Baseline: CMH has approximately 200 employees, 6 providers and 2 allied health workers who will need to be trained or –retrained in our QAPI processes. . Currently, we have 1 person who oversees performance improvement and quality improvement and we will work towards getting at least 2-4 more who are trained to help educate the 200 plus staff we have who need trained. We will use these train to create programs to help address CHF admission rates. We believe there are 1,500 patients in our service area with CHF and we hope to reduce the 100 admissions a year by 10 a year to begin with thru our Category 3 project. Also, CMH's primary service is approximately 16,000 in the Scurry County region of which the hospital sees approximately 8400 patient in the ED each year, over 16,000 outpatients visits a year, almost 1,000 outpatient surgeries a year and Cogdell Family Clinic sees approximately 20,000 patients a year. The starting point or baseline will be to take all of our employees and go through a detailed training process and develop process improvement plans to go our methods whereby we are able to not only look at issues current in our facility but ways we can develop processes to help improve the health of our patients before they get admitted to the hospital, for instance, being able to follow up with our patients to ensure they are following through with the prescribed treatment plan of their physician will help ensure the patient is taking care of themselves as well as reduce future healthcare costs.

Rationale: The project option chosen by CMH is 1.10.1 which is enhancing improvement capacity within people. With this project CMH will create new initiatives and significantly enhance existing ones in order to provide better quality service and improve performance throughout the organization. This option includes a) provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture and b) develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. It is very critical to its community and its ability to provide services which are needed by the employees, patients and the community. Because of this, this project will affect CN.1 and CN.3 to help develop improved ways through process improvement and quality improvement to ensure patients can see a primary care provider timely and those who are uninsured or underinsured will be able to get the best care possible. In project 1.10.1, CMH will develop or enhance its quality improvement process through training of its staff, purchasing an online quality improvement module to help track and monitor trends, implement a suggestion box through electronic means and develop processes which will focus on patient outcomes and their health. In doing this, CMH will show process milestones of P-1, P-2, P-5,P-6, I-7, and I-8. In doing all of this, CMH will be better able to serve its population and help to ensure those patients with chronic conditions are seen timely and their needs addressed.

Related Category 3 Outcome Measure(s): IT 2.1 CHF Admission Rate, by enhancing our performance improvement process, CMH should be able to reduce the CHF admission rate through treating more patients timely, following up on continued treatments to ensure patients are staying on their plan.

Relationship to other Projects: This project will have a relationship to projects 136330107.1.1; expand access to primary care & 136330107.2.1, Redesigning primary care. The relationship to these other projects will only be based on our ability to enhance our process improvement and the expansion of reporting. Thru enhancing our process and quality we will be able to develop strategies which will help improve the operational efficiency of the clinic, scheduling, and walk-in clinic. In reality these projects are not related and not dependent on each other, but as with the rest of the hospital when we enhance our process improvement and our reporting capacity it will help us better define key areas to focus on and drive our resources to the ones which need the greatest attention. Also, the project we have selected will also help us better position ourselves to meet the ever changing mandates from the state and federal government. By developing our processes CMH will be able to see patients more timely; patients will have the ability to get all of their services needed and the community will have an organization it can truly believe in and depend on. With the increase in staff in QI, we will be able to better develop and train the rest of the hospital's staff to ensure they are constantly looking for ways for the hospital to improve the way it provides services to our patients. Also, thru the development of dashboards

and scorecards our employees, patients and community will know where we stand in providing the best quality care while maintaining an efficient operation to ensure their tax dollars are being utilized in the best way possible. We believe in being transparent to our community and thru the suggestion box we will be able to address any issues and the community will be able to see their voices are being heard. Also, the hospital will work on redeveloping its culture, thru the improved reporting capacity and the use of dashboards and other various reporting tools, we will be able to show our employees the new culture we are seeking does work and will also be able to show our employees the effects of running a customer service culture and one that truly cares will pay off thru increased volumes, trust in each other, trust by our patients and community. Also, our QAPI will develop a team which will coordinate efforts among the hospital departments to ensure proper and timely follow up on our patients thru our ability to collect and analyze data; the reports generated from this data and our development of train the trainer process.

Relationship to Other Performing Providers' Projects in the RHP: : Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation: The valuation of this project is $1,755,510. Through the recruitment of 3 more primary care physicians, 2-3 more Pas/NPs, increase the hours of service, add a walk in clinic, develop better processes to follow up with patients on their treatment plans through the involvement of home health, case management and the clinic staff, address any post discharge issues, reduce non-emergent visits, and help reduce healthcare cost through these new processes.

Criteria	Narrative	Value

Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • By enhancing our quality and performance improvement processes CMH will be able to attend to patients more timely addressing their health needs as well as ensuring they are staying on their prescribed treatment plan to help reduce health care cost and address the low income and uninsured population to ensure they can get affordable healthcare. • There will be large amounts of infrastructure through the development of an on-line QI module, an electronic suggestion box, more staff needed and more education and training required. • The development of our processes will allow better coordination of the hospitals staff, especially, case management, its home health and its clinic, delivery will be improved and better processes developed by these coordinated efforts • This project will improve the patient outcomes at the same time reduce cost by patients accessing the appropriate setting. Performing Providers may consider the following attributes when scoring projects on this domain: • The project will be able to tie to 1.1.2 & 2.3.1 as well as IT 2.1 • Does the project primarily impact Medicaid and/or uninsured residents? Yes it will allow more affordable health care and ensure those on Medicaid can get in to see a provider. • How significant is the expected impact? To what extent will it "move the dial"? The impact is very significant and it will move the pendulum in the right direction to improve health and reduce costs • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact? Yes there is very strong evidence shown to support the hospitals plan	**5**

Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: • The project will address many needs of the community by have the coordinated efforts and working to ensure those without insurance do have access to affordable care. • How significant is the expected impact? To what extent will it "move the dial"? please see narrative above • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact? Please see narrative above	**5**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in • This project will reach our entire population base as well as affect the other major regional cities in which our patients have to go for services • Providers recruited/trained - 3 and 2-3 NPs/Pas as well as hiring additional staff for the QI department • Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations will be substantial	**5**
Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: • Human resources will the major focus point of this project and will require a significant investment and growth • Equipment purchase and maintenance not a large amount required except the QI module and the electronic suggestion box • Legal and professional fees will be great in order to get the contracts in and employ the providers • Time to implement will be over the waiver period • Risk assessment has been done and all risk will be there, but every attempt to minimize	**5**

	• Organizational priorities as with the other projects, it will be a top one.	

136330107.1.3 – "PASS 3B"	***1.10.1***	***1.10.1. A-B***	**Enhance Improvement capacity within people**
Cogdell Memorial Hospital			*136330107*
Related Category 3 Outcome Measure(s):	136330107.3.6	*IT 2.1*	*Congestive Heart Failure Admission Rate*

Year 2 '12 – '13	**Year 3 '13 –'14**	**Year 4 '14-'15**	**Year 5 '15-'16**
Milestone 1: P-1 Est. a performance improvement office to go from 1 who oversees to at least two people who are trained to oversee QI/PI. Metric 1 P-1.2 – documentation that the performance improvement office is engaged in collecting analyzing and managing real-time data Baseline/Goal: Enhanced performance improvement reports Data Source: Excel Files Milestone 1 Estimated Incentive Payment: $216,446 **Milestone 2**: Establish a program for trained experts to mentor and train staff work to get all 200 employees and 8-10 providers trained. Metric 1 – P-2.1 – Train the trainer Baseline/Goal: Develop train the trainer system for QI Data Source: Hospital Records should the trained experts Milestone 2 Estimated Incentive Payment: $216,446	**Milestone 3** [P-5]: Enhance or expand organizational infrastructure Metric 1 [P-5.1]: Increased collection of patient experience and/or quality measures data Baseline/Goal: To increase the amount of data collected in relation to quality measures Data Source: Documentation of quality measures data collection and reporting Milestone3 Estimated Incentive Payment: $240,174 **Milestone 4**: P-6: Hire train quality improvement staff add at least one more person to help oversee as part of their job duties Metric 1: P 6.1 – Increase number of trained staff Baseline/Goal: To increase the QI department by 1 staff Data Source: Hospital HR Records and training programs Milestone 4 Estimated Incentive Payment: $240,174	**Milestone5** [I-7]: Implement quality improvement data systems Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Goal: Implement QI Module Data Source: QI data Systems work to generate at least an overall summary report on all areas of the hospital and detailed departmental reports estimated at approximately 60-75 Milestone 5 Estimated Incentive Payment: $461,840	**Milestone 6** [I-8]: Create a dashboard Metric 1 [I-8.1]: Submission of quality dashboard or scorecard Goal: The creation of a dashboard or scorecard Data Source: QI dashboard/scorecard Milestone 6 Estimated Incentive Payment: $380,430

136330107.1.3 – "PASS 3B"	***1.10.1***	***1.10.1. A-B***	**Enhance Improvement capacity within people**
Cogdell Memorial Hospital			*136330107*
Related Category 3 Outcome Measure(s):	136330107.3.6	*IT 2.1*	*Congestive Heart Failure Admission Rate*

Year 2 '12 – '13	**Year 3 '13 –'14**	**Year 4 '14-'15**	**Year 5 '15-'16**
Year 2 Estimated Milestone Bundle Amount*:* $432,892	Year 3 Estimated Milestone Bundle Amount: $480,348	Year 4 Estimated Milestone Bundle Amount: $461,840	Year 5 Estimated Milestone Bundle Amount: $380,430
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,755,509			

Project Option: 1.1.2 Expand Existing Primary Care Capacity
Performing Provider: Dallam-Hartley Counties Hospital District dba Coon Memorial Hospital/130826407
Unique Project ID: 130826407.1.1
Project Components: 1.1.2.a-c

Provider: Coon Memorial Hospital is a 21-bed critical access hospital located in Dalhart, Texas serving two counties, Dallam County and Hartley County. The combined population of the two counties is approximately 12765. Coon Memorial Hospital is included in the Dallam-Hartley County Hospital District, which also includes a nursing home, assisted living, Dalhart Family Medicine Rural Health Clinic, physical therapy clinic, occupational health clinic, and a surgery clinic. In addition, the district provides several specialty services which are provided by visiting providers. The hospital emergency room is a level four trauma center. The district is located 96 miles from the nearest significant healthcare facilities in Amarillo, Texas.
Intervention(s): This project will expand the capacity of the Rural Health Clinic to provide primary care services for the target population. In addition to adding providers, this plan includes altering the existing hours in order to provide primary care during after hours and weekends.
Need for the Project: The rural health clinic experienced 20338 encounters during our last fiscal year, the existing providers are currently at or above capacity. There are significant instances of either excessive wait times to see a primary care provider (over three days for initial visit) or no openings at all for new and existing patients. In addition, there is currently no primary care available after hours or weekends. Due to these factors, patients are either directed to the emergency room, go to the emergency room on their own, or have to travel to a provider in another city. Indigent patients or those without insurance also rely on the emergency department for their health care since there is not sufficient primary care capacity. Also, since most of the target population cannot afford to leave work to seek care for themselves or their children, they use the health care that is available, the emergency department. There is no urgent care facility within 96 miles which makes such care out of reach for many of our service population. The goal of this project is to increase primary care encounters by 20% at the end of the five year plan by increasing the number of primary care providers and offering care for additional hours.
Target Population: The target population is the residents in our service area that need a primary care home. Medicaid patient population is 1,442 in Dallam County and 701 in Hartley County with the uninsured population around 2437 and 1582 respectively, (As reported in the health facts profile from Texas Department of State Health Services for2009, most recent data). This places approximately 48% of the service population as either Medicaid or indigent/uninsured. This project should increase primary care encounters by 20% over the plan period, or from the 20338 encounters for the last year to 24405 primary care encounters at the end of the plan period.

Category 1 or 2 expected patient benefits: This project should increase primary care encounters by 20% over the plan period, or from the 20338 encounters for the last year to 24405 primary care encounters at the end of the plan period. In addition it will extend clinic hours to make primary care more available and reduce unnecessary emergency room visits.
Category 3 outcomes: Percent improvement over baseline of patient satisfaction scores.

Project Option: 1.1.2 Expand Existing Primary Care Capacity
Performing Provider: Dallam-Hartley Counties Hospital District dba Coon Memorial Hospital/130826407
Unique Project ID: 130826407.1.1
Project Components: 1.1.2.a-c

Project Description:

There are currently not sufficient primary care providers to provide reasonable primary care to the resident of Dallam-Hartley counties. Consequently, our residents either wait an extended period of time to see a provider, go to the emergency room for care, or travel to another city to see a provider. We plan to address this issue by adding additional providers in the Rural Health Clinic to increase Primary Care Coverage; re-design existing clinic space to increase the number of examination rooms, re-design processes to provide for expanded clinic hours. Introduce triage in the Emergency Room evaluation processes to re-direct non-emergent patients to the expanded clinic for care and treatment. The goal or 5-year expected outcome, will be to increase our district's ability to provide Primary Care for our residents by 20% over the project time-line based on historic Primary Care encounters. The significant challenges to reaching this goal will be 1) Expanding the medical staff and support staff and training; 2) Re-designing the limited existing clinic space to provide adequate and efficient space for expanded Primary Care; 3) Re-designing current processes to allow for expanded clinic hours; 4) Obtaining additional equipment as needed.

We believe that this project complies with the overall vision or goal for the Region 12 RHP which is to assure residents receive high-quality, patient-centered care, in a cost effective manner that focuses on coordinated care delivery and improved health outcomes, with a particular focus on the Medicaid and uninsured residents, while containing cost growth. The vision is to fulfill as many of the community needs identified in the area as possible focusing on those identified as urgent and critical needs. (CN.2: Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.)

Dallam-Hartley Counties Hospital District serves two counties in the Texas Panhandle comprising approximately 11,759 citizens. The uninsured adults in Hartley County are 16% and for Dallam County it is 23%, uninsured children under the age of 18 is 19% and 23% respectively. The balance of residents either have private health insurance or are covered by either Medicare and/or Medicaid. The primary industry for both counties is agriculture related, with the major companies offering health insurance coverage but the majority of privately owned agriculture likely does not offer insurance to their employees. Currently, significant numbers of the under or un-insured or Medicaid residents are unable to find a medical home with an existing primary care provider, instead turning to the emergency room for their primary care. This project is focused at adding additional primary care services to re-direct those that use the emergency room when the situation is not emergent to a medical home with a primary care provider and to offer additional capacity for those residents that cannot find a medical home in our area.

Some statistical information for the two counties is listed below:

Dallam County 73% urban, 27% rural

Type of workers

Private wage or salary: 71% Government: 15% Self-employed, not incorporated: 13% Unpaid family work: 1%

Races in Dallam County, Texas: White Non-Hispanic Alone (61.7%) Hispanic or Latino (33.6%) Black Non-Hispanic Alone (2.4%) American Indian and Alaska Native alone (1.0%) Some other race alone (0.7%)

Median resident age: 31.4 years

Males: 3,142 (50.5%)

Females: 3,080 (49.5%)

Estimated median household income in 2009: $33,777 ($27,946 in 1999)

Percentage of residents living in poverty in 2009: 12.5% (10.2% for White Non-Hispanic residents, 36.1% for Black residents, 14.4% for Hispanic or Latino residents, 21.3% for American Indian residents, 17.9% for other race residents, 41.2% for two or more races residents)

Residents with income below the poverty level in 2009: 14.1%

Residents with income below 50% of the poverty level in 2009: 6.7%

Adult diabetes rate: 8.5%

Adult obesity rate: 26.8%

Hartley County

(42% urban, 58% rural)

Type of workers:

Private wage or salary: 69% Government: 17% Self-employed, not incorporated: 14%

Unpaid family work: 0%

Races in Hartley County, Texas: White Non-Hispanic Alone (72.9%) Hispanic or Latino (18.0%) Black Non-Hispanic Alone (7.8%) Two or more races (0.6%)

Median resident age: 39.6 years

Males: 3,358 (60.6%)

Females: 2,179 (39.4%)

Estimated median household income in 2009: $55,994 ($46,327 in 1999)

Percentage of residents living in poverty in 2009: 5.9%

(3.7% for White Non-Hispanic residents, 0.0% for Black residents, 22.6% for Hispanic or Latino residents, 84.6% for American Indian residents, 0.0% for other race residents, 0.0% for two or more races residents)
Residents with income below the poverty level in 2009: 6.6%
Residents with income below 50% of the poverty level in 2009: 1.8%
Adult diabetes rate: 9.3%
Adult obesity rate: 29.0%

Starting Point/Baseline:

For our Fiscal Year ending in July 2012, the primary care clinic serviced four primary care physicians and one mid-level provider which handled 20,338 patient encounters.

Rationale:

This project was selected based on the needs of the community needs assessment problem CN.1 Severe primary care provider shortage, wait time, expense, lack of insurance, access to care. We feel that we can best address this need by expanding our existing primary care capacity by increasing the number of providers in our under-served area, expanding clinic space, and offering extended clinic hours thus significantly enhancing our ability to provide primary care. In turn, we believe that this project will reduce the number of unnecessary Emergency Room visits occurring because a resident of our community is unable to see a Primary Care provider due to availability or time constraints. Core Components: a) Expand primary care clinic space – Our plan will meet this core component by remodeling existing clinic space to create additional exam rooms (current plans indicate that we will be able to add 3 additional exam rooms). b) Expand primary care clinic hours – Our plan will meet this core component as the new clinic area will operate from mid-morning/noon for eight hours so that the clinic is open into the evening. The current clinic hours are from 8 a.m. to 5 p.m.; c) Expand primary care clinic staffing – Our plan includes the intention of recruiting at least one family practice physician as well as up to two mid-level providers.
Milestone selection: We selected the milestones that we believed best supported the project intention for creating additional capacity in the area of Primary Care. This additional capacity will be achieved by 1) creating additional clinic space which will be required to facilitate the additional Practioner and support staff; 2) Expanding the hours which the additional clinic will operate giving our population an opportunity to receive primary care after normal working hours so they will not be required to leave work or school for this purpose. Provide a window for our Medicaid and poverty population to seek care in a clinic setting as opposed to the Emergency Room setting. Milestones selected; P-1, P-4, I-12, I-13

Related Category 3 Outcome Measures:

OD-6-Patient Satisfaction

IT-6.1 Percent Improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) Currently, our Primary Care providers are unable to provide adequate care to our community because there are just not enough providers to do so. Many residents are unable to get appointments with the providers in a timely manner and results in either the patient using the Emergency Room as their Primary Care Provider or driving to another city over ninety miles away for Urgent care services. We are a Health Professional Shortage Area and currently underserved in Primary Care so this is the area where we have the greatest need in supporting our community needs.

Relationship to Other Projects: *N/A*

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Achieves Waiver Goals:

This plan will achieve the proposed waiver goals as it expands our hospital district's ability to provide primary care to the residents that we serve. By expanding primary care, we intend to divert our Medicaid and uninsured patients as well as all non-emergent patients from using the Emergency Room to a Primary Care setting thereby significantly reducing the cost of treatment. We also anticipate that the extended clinic hours will benefit our population by reducing their need to take time from work or school, which many of the target population cannot afford, to receive care.

Addresses Community Needs:

This project will directly address the number one need in the community assessment problem CN.1 Severe primary care provider shortage, wait time, expense, lack of insurance, access to care. Increasing our Primary Care Capacity by 20% over the plan period, we expect, will have a significant impact on meeting the needs of our communities, reducing healthcare costs by reducing the un-emergent treatments performed in our Emergency Room and allow our residents a better continuity of care and reduced costs by having sufficient primary care providers to allow our residents to have their "own" family doctor.

Project Scope/Size:

We currently only have this one project. This project should increase clinic encounters 20% over the plan period and is focused on providing additional care to the targeted population by opening the clinic extended hours. The savings from unnecessary ER visits is yet TBD.

Project Investment:

Significant investments will include the recruitment and hiring costs associated with physician and mid-level placement. There will also be additional costs as related to hiring and training support personnel and the remodeling of existing clinic space. We also anticipate needing to overcome some significant objections by the existing providers.

130826407.1.1	*1.1.2*	*1.1.2.A-C*	*EXPAND PRIMARY CARE CAPACITY/EXPAND EXISTING CAPACITY*
Dallam-Hartley Counties Hospital District dba Coon Memorial Hospital			**130826407**
Related Category 3 Outcome Measure(s):	**130826407.3.1**	***IT-6.1***	**Percent improvement over baseline of patient satisfaction scores**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-1 Establish additional/expand existing/relocate primary care clinic. **Metric 1: P-1.1** Number of additional or expanded hours or space. **Baseline/Goal:** Documentation of detailed expansion plans **Data Source:** New primary care schedule or other Performing Provider document or other plans as designated by Performing **Milestone 1 Estimated Incentive Payment:** $ 385,263	**Milestone 2**: **P-4** Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric 1 [P-4.1]:** Increased number of hours at primary care clinic over baseline **Goal:** Expand clinic hours to increase capacity **Data Source:** Clinic hour expansion documentation **Milestone 2 Estimated Incentive Payment:** $ 446,571	Milestone 3: P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. **Metric 1**: P-5.1 Documentation of increased number of providers and staff and/or clinic sites. Goal: Sufficiently increased number of providers and staff to expand services Data Source: Hiring and training documentation Milestone 4 Estimated Incentive Payment: $225,593 Milestone 4: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase number of visits by 5% over prior year. Data Source: Patient/treatment Logs. Milestone 5 Estimated Incentive Payment: $ 225,593	Milestone 5: I-13.1 Enhanced capacity to provide urgent care services in the primary care setting. Metric 1: I-13.1 Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Goal: Demonstrate improvement over baseline rates by 10% Data Source: Patient/treatment logs. Milestone 5 Estimated Incentive Payment: $ 386,566 Milestone 6: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: I-12.1 Documentation of increased

130826407.1.1	*1.1.2*	*1.1.2.A-C*	*EXPAND PRIMARY CARE CAPACITY/EXPAND EXISTING CAPACITY*	
Dallam-Hartley Counties Hospital District dba Coon Memorial Hospital				**130826407**
Related Category 3 Outcome Measure(s):	**130826407.3.1**	***IT-6.1***	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**		**Year 5 (10/1/2015 – 9/30/2016)**
				number of visits. Demonstrate improvement over prior reporting period. Goal: Increase number of visits by 5% over prior year. Data Source: Patient/treatment Logs. Milestone 6 Estimated Incentive Payment: $ 225,593
Year 2 Estimated Milestone Bundle Amount: $385,263	**Year 3 Estimated Milestone Bundle Amount:** $ 446,571	**Year 4 Estimated Milestone Bundle Amount:** $ 451,186		**Year 5 Estimated Milestone Bundle Amount:** $ 386,566
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,669,586				

Project Option: 1.8.6 – The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours
Performing Provider: Dallam-Hartley Counties Hospital District dba Coon Memorial Hospital/130826407
Unique Project ID: 130826407.1.3 – "PASS 3b"

Provider:
Coon Memorial Hospital is a 21-bed critical access hospital located in Dalhart, Texas serving two counties, Dallam County and Hartley County. The combined population of the two counties is approximately 12765. Coon Memorial Hospital is included in the Dallam-Hartley County Hospital District, which also includes a nursing home, assisted living, Dalhart Family Medicine Rural Health Clinic, physical therapy clinic, occupational health clinic, and a surgery clinic. In addition, the district provides several specialty services which are provided by visiting providers. The hospital emergency room is a level four trauma center. The district is located 96 miles from the nearest significant healthcare facilities in Amarillo, Texas.

Intervention(s): This project will implement dental services to the district for the purpose of serving the target population of Medicaid children, Nursing Home residents, and the under- or un-insured located in our service area. The existing dentist located in our area do not accept these patients and the nearest dental provider that does is over 96 miles away.

Need for the Project: There are two dental providers located in our service area, neither of which will accept Medicaid patients, Nursing Home Residents, or indigent/un-insured without cash payment arrangements. This project will be directly aimed at providing dental services to residents within our district that are unable to otherwise receive such care, focusing primarily on Medicaid children and Nursing Home residents which are primarily Medicaid recipients. It will also eliminate the need for indigent or underinsured patients from seeking dental care in the Emergency Room. In addition, the nearest dental care for this targeted population is in excess of 96 miles which is prohibitive.

Target Population: The target population is the residents in our service area that need a primary care home. Medicaid patient population is 1,442 in Dallam County and 701 in Hartley County with the uninsured population around 2437 and 1582 respectively, (As reported in the health facts profile from Texas Department of State Health Services for2009, most recent data). This places approximately 48% of the service population as either Medicaid or indigent/uninsured. There are no dental services existing in our area targeting Medicaid children. We anticipate our initial capacity to be approximately 1728 dental patients per year after the clinic is established and the dental provider is in service. We anticipate that it will take the first year to establish the clinic and communicate with the target population. Beginning in DY4 we anticipate increase the volume of visits to an additional 10% Medicaid/un-insured patients for total annual visits of 1900 and by DY 5, with

additional Dental providers/hygienists, etc. those visits are anticipated to reach 2280. As this is a new service for our Hospital District, the beginning baseline is zero, anticipated visits are estimates.

Category 1 or 2 expected patient benefits: This project will increase/improve dental care for Medicaid recipients, both children and Nursing Home residents, as well the indigent/uninsured . In addition it will extend clinic hours to make dental care more available and reduce unnecessary emergency room visits. We expect this project to address a significant need in our community as there are no dental services that are available to Medicaid or the un/under-insured without having to travel a significant distance. Over the course of the scope of this project, we hope to aide almost 6000 of our residents that either do not receive dental treatment, have to travel an excessive distance for the service, or visit our emergency department for relief.

Category 3 outcomes: Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

Project Option: 1.8.6 – The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours
Performing Provider: Dallam-Hartley Counties Hospital District dba Coon Memorial Hospital/130826407
Unique Project ID: 130826407.1.3 – "PASS 3b"

Project Description:

There are currently two dentists within our district (not associated with the district) that will not accept Medicaid patients, Nursing Home patients, or un-insured without cash payment arrangements. This project will be directly aimed at providing dental services to residents within our district that are unable to otherwise receive such care, focusing primarily at Medicaid children and Nursing Home residents. In addition, some of the targeted population currently resort to visiting our Emergency Room for dental services either because they are unable to see a local dentist or cannot afford to pay for the services since the existing dental offices do not accept Medicaid. The nearest dentist office that will accept Medicaid patients is over 96 miles from the hospital district, which is a prohibitive distance for many such patients to be able to go effectively. Nursing Home residents also must be transported more than 96 miles in order to see a dentist since most of these residents are covered by either Medicare or Medicaid. These trips are usually very difficult and tiring for the residents to make, therefore they are usually only done in emergency situations. Currently there are no trained dental personnel to work with the residents on preventive dental care.

The goal of this project is to establish dental services to Medicaid patients, particularly Medicaid children, Nursing Home residents, and un- or under-insured residents of the area in which the hospital district serves. Dental health is a key component of overall health. Oral disease can lead to poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes, and cardiovascular disease; and a diminished quality of life and life expectancy.36 Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic, and social consequences.37 Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing oral health services will improve health outcomes. Basic dental and hygiene services would be provided, to include cleaning, treatment of cavities, etc.

Specific Project Goals:

- Close gaps/disparities in access to dental care services: Provide basic dental services beginning with approximately 1700 patients per year increasing the visits to over 220 patients per year by the end of DY5. Target population is Medicaid & the un/underinsured.
- Enhance the quality of dental care
- Increase and enhance the dental workforce
- Redistribute and retain the dental workforce to/in underserved areas

Challenges - the recruiting of dental care professionals to come to our area to provide this service. Establishing a new dental clinic.

The five year expected outcome – to establish a reliable dental clinic that is able to meet the needs of the Medicaid patients, Nursing Home residents, and un- or under-insured residents in our service area.

Relationship to Regional Goals – Per the regions community needs assessment identifier CN 13 - there is a shortage of dental care. We believe that this project is important if not urgent for our specific area due to the lack of dental care for Medicaid insured patients and Nursing Home residents. It is difficult for this targeted population to travel where such services are available and the emergency room is not the proper place for such care as the emergency room personnel are not trained in the dental fields. This project should also help to develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Dallam-Hartley Counties Hospital District serves two counties in the Texas Panhandle comprising approximately 11,759 citizens. The uninsured adults in Hartley County are 16% and for Dallam County it is 23%, uninsured children under the age of 18 is 19% and 23% respectively. The balance of residents either have private health insurance or are covered by either Medicare and/or Medicaid. The primary industry for both counties is agriculture related, with the major companies offering health insurance coverage but the majority of privately owned agriculture likely does not offer insurance to their employees.

Currently, significant numbers of the under or un-insured or Medicaid residents are unable to find a medical home with an existing primary care provider, instead turning to the emergency room for their primary care. This project is focused at adding additional primary care services to re-direct those that use the emergency room when the situation is not emergent to a medical home with a primary care provider and to offer additional capacity for those residents that cannot find a medical home in our area.

Some statistical information for the two counties is listed below:

Dallam County

(73% urban, 27% rural)

Type of workers

Private wage or salary: 71% Government: 15% Self-employed, not incorporated: 13%
Unpaid family work: 1%

Races in Dallam County, Texas: White Non-Hispanic Alone (61.7%) Hispanic or Latino (33.6%)
Black Non-Hispanic Alone (2.4%) American Indian and Alaska Native alone (1.0%)
Some other race alone (0.7%)

Median resident age: **31.4 years**

Males: 3,142 **(50.5%)**
Females: 3,080 **(49.5%)**

Estimated median household income in 2009: $33,777 ($27,946 in 1999)

Percentage of residents living in poverty in 2009: 12.5%
(10.2% for White Non-Hispanic residents, 36.1% for Black residents, 14.4% for Hispanic or Latino residents, 21.3% for American Indian residents, 17.9% for other race residents, 41.2% for two or more races residents)

Residents with income below the poverty level in 2009: 14.1%
Residents with income below 50% of the poverty level in 2009: 6.7%

Adult diabetes rate: 8.5%
Adult obesity rate: 26.8%

Hartley County
(42% urban, 58% rural)

Type of workers:
Private wage or salary: 69% Government: 17% Self-employed, not incorporated: 14%
Unpaid family work: 0%

Races in Hartley County, Texas: White Non-Hispanic Alone (72.9%) Hispanic or Latino (18.0%)
Black Non-Hispanic Alone (7.8%) Two or more races (0.6%)

Median resident age: **39.6 years**

Males: 3,358 **(60.6%)**
Females: 2,179 **(39.4%)**
Estimated median household income in 2009: $55,994 ($46,327 in 1999)

Percentage of residents living in poverty in 2009: 5.9%
(3.7% for White Non-Hispanic residents, 0.0% for Black residents, 22.6% for Hispanic or Latino residents, 84.6% for American Indian residents, 0.0% for other race residents, 0.0% for two or more races residents)

Residents with income below the poverty level in 2009: 6.6%
Residents with income below 50% of the poverty level in 2009: 1.8%

Adult diabetes rate: 9.3%
Adult obesity rate: 29.0%

Starting Point/Baseline: As this is a new service for the hospital district for this targeted population, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2.

Rationale:
This project was selected to directly meet a need that we see in our community by providing dental services to Medicaid insured patients (with a focus on Medicaid children), and Nursing Home residents. This will be a new service for the hospital district, but one which has been greatly needed for some time. Over the last 12 months, we have seen at least 24 individuals in our Emergency Room seeking dental care. These patients have been predominantly Medicaid insured children or patients without any form of dental insurance. In addition, the residents of our Nursing Home (predominantly Medicaid patients) receive no regular dental care. The existing dentists have chosen not to provide these services to this population. Furthermore, we believe that it is important to provide dental services to un- or under-insured patients at a reduced cost or at no cost if necessary in order to promote better healthcare for our residents and the targeted group. The project components were selected to create and/or increase dental services to the targeted population. As these services are not available within 96 miles of our district, we believe this to be a very important project. The milestones selected were chosen as they directly facilitate the successful completion of this project. (Milestone P-4 Metric P-4.1; establish additional/expand existing dental care clinics: Milestone P-5, Metric P-5.1; Milestone P-2, Metric P-2.1, P-2.2; I-13, Metrics I-13.1, I-13.2; Milestone I-11, Metric I-11.4; Milestone I-14, Metric I-14.1
This project will directly address the RHP 12 community needs assessment CN 13, need for dental services.

Related Category 3 Outcome Measure(s): Outcome Measure 7.2; Cavities: Percentage of Children With Untreated Dental Caries (Health People 2002)
Oral health is essential to overall health. We must initiate methods to improve monitoring and evaluating oral health and conditions. The CDC reports the most recent period shows high levels of untreated cavities: 19.5% in children ages 2-5 and 22.9% in children 6-19. 42% of children have had dental caries in their primary teeth. Black and Hispanic children and those living in low income families have more decay. Unmet needs: 23% of children 2-11 have untreated dental care. Our District is currently unable to provide this service to Medicaid, underinsured, non-insured/low income children, as we do not have a dentist that provides services to this population. This is the reason that we chose this project, Project 1.8.6 will establish these services for the targeted population.

Relationship to other Projects: This project only relates to the associated Category 3 project 7.2.

Relationship to Other Performing Providers' Projects in the RHP: This project does not relate to any other performing providers in the RHP

Plan for Learning Collaborative: None

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways • Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties • Further develop and maintain a coordinated care delivery system • Improve outcomes while containing cost growth Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project impact one or more of the goals? • Does the project primarily impact Medicaid and/or uninsured residents? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**5**
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project address one or more community need? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**5**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in • Outreach to the targeted population • Patient visits/encounters • Providers recruited/trained • Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**5**

130826407.1.3 – "PASS 3b"	1.8.6	N/A	The expansion of existing dental clinic, the establishment of additional dental clinics, or the expansion of dental clinic hours.
Dallam-Hartley Counties Hospital District dba Coon Memorial			**130826407**
Related Category 3 Outcome Measure(s):	**130826407.3.3**	**3.IT-7.2**	Cavities: Percentage of Children With Untreated Dental Caries (Healthy People 2020)7.2

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1 (P-4). Establish additional/expand existing/relocate dental care clinics or space **P-4.1 Metric**: Number of additional clinics, expanded space, or existing available space used to capacity a. Documentation of expansion or efficient use of existing space b. **Data Source:** New dental care schedule or other document, completed exams, treatment plans **Baseline/Goal:** This project will provide a service that is not existing at this time. The baseline will be historical data in our area as provided by the CDC and Texas Health and Human Services. The goal is to initiate these services for Medicaid children, Nursing Home Residents, and low income residents in our service area. As a new service, the baseline is zero. **Estimated Milestone 1 Incentive Payment:** $247,988	***Milestone 2 (P-5):*** Expand the hours of a dental care clinic or office, including both evening and/or weekend hours **P-5.1. Metric:** Increased number of hours at dental care clinic or office over baseline, number of patients served during extended hours a. Documentation of increased hours and patients served b. **Data Source:** Clinic or office hour documentation, patient records, patient schedule ***Estimated Milestone 2 Incentive Payment:*** *$161,219* **Milestone 3 (P-5)**: Expand the hours of a dental care clinic or office, including both evening and/or weekend hours **P-5.1. Metric**: Increased number of hours at dental care clinic or office over baseline, number of patients served during extended hours	***Milestone 4 (P-2):*** Milestone: Increase recruitment or retention program for dental care providers in underserved markets **P-2.1. Metric:** Establish and market available loan repayment programs to fourth year dental students, dental residents, and dental hygienists a. Documentation of loan repayment program b. **Data Source:** Program materials **P-2.2 Metric:** Establish or increase scholarships for advanced training/education in a dental specialty with written commitments to practice in underserved markets after graduation a. Documentation of scholarships b. **Data Source:** Program materials ***Estimated Milestone 4 Incentive Payment:*** *$131,828* **Milestone 5 (I-11):** Increase dental care training:	**Milestone 6 (I-13):** Increase access to dental care in rural and underserved areas of the state **I-13.1. Metric**: Increased number of dental care professionals serving rural and unserved populations a. Numerator: Provider:patient ratio after intervention b. Denominator: Original provider:patient ratio c. **Data Source:** Survey of local rural dental resources **I-13.2. Metric:** Additional rural areas with local dental access (Local dental access is defined as a dental care facility within 75 miles) c. **Data Source:** Survey of local rural dental resources **Estimated Milestone 6 Incentive Payment:** $172,205 **Milestone 7 (I-14):** Increase number of special population members that access dental services **I-14.1. Metric:** Increasing the

130826407.1.3 – "PASS 3b"	1.8.6	N/A	The expansion of existing dental clinic, the establishment of additional dental clinics, or the expansion of dental clinic hours.	
Dallam-Hartley Counties Hospital District dba Coon Memorial			**130826407**	
Related Category 3 Outcome Measure(s):	**130826407.3.3**	**3.IT-7.2**	Cavities: Percentage of Children With Untreated Dental Caries (Healthy People 2020)7.2	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
	a. Documentation of increased hours and patients served b. **Data Source:** Clinic or office hour documentation, patient records, patient schedule **Estimated Milestone 3 Incentive Payment:** $107,479 *Baseline/Goal Baselin 0/Goal to provide basic dental care to NH residents and 20% of the Medicaid and un/underinsured population over the prior year.*		**I-11.4. Metric:** Percentage of dentists incorporating special population patients into their practices following special population continuing education, in-service trainings, lunch and learn presentations. c. **Data Source:** Post-training survey **Estimated Milestone 5 Incentive Payment:** $131,827 Baseline/Goal Baseline 0/Goal to provide basic dental care to NH residents and 30% of the Medicaid and un/underinsured population over the prior year.	number of children, special needs patients, pregnant women, and/or the elderly accessing dental services for the past 12 months. b. **Data Source:** Billing, consent forms, other documentation of dental services dental care. **Estimated Milestone 7 Incentive Payment:** $172,204 **Milestone 8 (I-11):** Increase dental care training: **I-11.4. Metric:** Percentage of dentists incorporating special population patients into their practices following special practices following special population continuing education, in-service trainings, lunch and learn presentations. c. **Data Source:** Post-training survey **Estimated Milestone 8 Incentive Payment:** $131,827

130826407.1.3 – "PASS 3b"	1.8.6	N/A	The expansion of existing dental clinic, the establishment of additional dental clinics, or the expansion of dental clinic hours.	
Dallam-Hartley Counties Hospital District dba Coon Memorial			**130826407**	
Related Category 3 Outcome Measure(s):	**130826407.3.3**	**3.IT-7.2**	Cavities: Percentage of Children With Untreated Dental Caries (Healthy People 2020)7.2	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
				Baseline/Goal Baseline 0/Goal to provide basic dental care to NH residents and 30% of the Medicaid and un/underinsured population over the prior year.
DY 2 Estimated Milestone Bundle Amount: $247,988	DY 3 Estimated Milestone Bundle Amount: $268,699		DY4 Estimated Milestone Bundle Amount: $263,655	*DY5 Estimated Milestone Bundle Amount: $230,754*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,011,096				

Project Option: 1.3.1 Implement/enhance and Use Chronic Disease Management Registry Functionalities
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.1.1

- **Provider:** GPCH is a 25-bed hospital in Borger, Texas serving an 895 square mile area and a population of approximately 21,000 (primary) and an additional 30,000 (tertiary). Although GPCH is located in a rural part of Texas, the hospital provides a healthcare safety-net for the industrial local community within its service area.
- **Intervention(s):** GPCH clinical staff will create a longitudinal register database of health care utilization and services for Hutchinson County patients diagnosed with COPD, which is a common chronic disease in the community (likely due to the community's oil refinery, nitrogen fertilizer plant, carbon black plant, and dry, dusty climate). The goal is to identify previously undiagnosed COPD patients, intervene earlier in thedisease to prevent hospitalization, and to follow up post-hospitalization to prevent re-admission, thus decreasing the cost and impact of this disease. This project will be performed through the collaboration with Northwest Texas Healthcare System, a private hospital located in Amarillo, and is intended to effect transformation of the regional healthcare delivery by allowing rural COPD patients to receive appropriate care in their communities, in order to prevent costly complications and transfers to urban areas like Amarillo, where providers are already providing care to urban residents at full capacity.
- **Need for the project**: Approximately ten percent of the 12,000 patients that present at GPCH annually have been diagnosed with COPD or COPD-like symptoms (approximately 1200 patients), and 44% are uninsured or Medicaid eligible. GPCH expects the number of diagnosed COPD or pre-COPD patients to double over the course of the Waiver, in light of how many "lung-related" ED visits GPCH experiences each year. It is imperative to routinely manage and monitor COPD patients in order to reduce the cost of providing healthcare to this population and to improve the health outcomes of COPD patients. Clinic and hospital staff must be able to track their COPD patients to meet these goals.
- **Target population:** The target population of this project is patients suffering from or at risk for COPD in GPCH's catchment area (currently estimated to include 1200 unique patients). Specifically, the project seeks to manage the treatment for Medicaid and uninsured COPD patients in the hospital's catchment area, which GPCH estimates to include 528 patients now and expects to grow to 1056 over the Waiver.

- **Category 1 or 2 expected patient benefits:** The registry will allow GPCH to increase COPD patient touches for Hutchinson County residents by 15% over the baseline rate by the end of DY5.
- **Category 3 outcomes:** IT 10.1 – By DY5, GPCH expects to demonstrate a 10% improvement over the baseline quality of life scores, as measured by an evidence-based and validated assessment tool for COPD patients in Hutchinson County who are entered into the registry. GPCH will use the Missoula-VITAS Quality of Life Index (MVQOLI) Survey to measure changes.

Project Option: 1.3.1 Implement/enhance and Use Chronic Disease Management Registry Functionalities
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.1.1

Project Components: 1.3.1.a-d

Project Description:
GPCH clinical staff will create longitudinal register database of health care utilization and services for Hutchinson County patients diagnosed with COPD, which is a common chronic disease in this industrial community. The goal is to intervene earlier in the course of the disease to prevent hospitalization, and to follow up in the case of a hospitalization to prevent re-admission, thus decreasing the cost and impact of this disease. These steps should decrease the rate of hospitalization and LOS for patients with COPD. Care providers will receive regular reports regarding the status of the chronic disease patients in their panel. COPD patient care will be more effective if we can interact with the patient in the earlier stages of the disease and earlier in the progression of any acute episodes.
The flow of the project will include: creating the technological infrastructure to support the registry; reviewing and sorting patient records to identify Hutchinson County patients with COPD; inputting the COPD patients' health information into the database; training GPCH staff to use the registry for outreach and health management; implementing the use of the registry.

Project goals: Ultimately, the disease registry will allow the hospital to increase its awareness of the patient's condition, to help the patient adhere to care recommendations, reduce visits to the ED and admissions to GPCH and other area hospitals. In turn, the hospital will use this additional information to create a plan to improve the quality of its care to these patients, and will create a report of lessons learned from the project. More broadly, the goal of this project is to transform the healthcare delivery process in Region 12 to prevent the migration or transfer of rural patients to urban centers (such as Amarillo) due to lack of adequate care in their communities or an inability to effectively manage and treat specific conditions.

o The registry will allow GPCH to increase COPD patient touches for Hutchinson County residents by 15% over the baseline rate by the end of DY5.

Project challenges: Expected challenges include that many of these patients are seen at various providers around the area, with little or no coordination, making the data difficult to gather. Also, many chronic patients have a tendency to be non-compliant with medical advice, only seeking intervention when their conditions become urgent (which often necessitates transfer to Amarillo for treatment). GPCH intends to confront these challenges by reaching out to other area providers and/or the patients themselves to gather relevant health data, and by engaging in patient education through developing and maintaining the registry.

Five Year Expected Outcome: As stated above, GPCH expects the registry to result in an increase by 15% in GPCH clinic patient touches for Hutchinson County residents suffering from COPD.

Relationship to Regional Goals: This project relates to regional goals by aiming to transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes.

Starting Point/Baseline:
During DY2, GPCH will determine the following: how many Hutchinson County residents suffer from COPD; how many GPCH hospital admissions per year are due to complications from COPD.

Rationale:
GPCH chose this project because according to the Region 12 Community Needs Assessment, 230 rural residents died of COPD in 2004. This constitutes 3% of deaths from COPD statewide, although the Region 12 rural area only comprises 1.5% of the state population. Additionally, 9% of Hutchinson County respondents surveyed for the Community Needs Assessment reported having at least one person with severe breathing issues in their household. Finally, when polled, respondents from Hutchinson County listed COPD as one of the most prevalent health issues in the County. Thus, COPD is a health issue that needs to be addressed and controlled in Hutchinson County.

Core requirements: When GPCH enters the data into the registry, it will allow the providers to identify, track, and manage patients with COPD, satisfying core components (a) and (b). When the providers use the registry to reach out to patients, there is a much greater likelihood that patients will keep up with regular primary care visits, treatment, and lifestyle initiatives suggested by their care providers. Creating the registry will allow GPCH to create and implement a quality improvement plan for measuring the effects of the registry in DY4 (satisfying core component (c)), which will either alert GPCH that is engaged in a successful best practice that needs to continued and even expanded, or that the hospital needs to consider a different approach to reaching and managing the conditions of patients with COPD. Finally, in order to satisfy core component (d), GPCH will assess opportunities to expand the COPD registry to other targeted chronic disease populations in GPCH's catchment area in DY5.

Milestones and Metrics: GPCH chose the DY 2-3 milestones and metrics to support creating the registry, infrastructure, policies, and baseline necessary to track improvement. The milestones and metrics for DY 4-5 are meant to measure GPCH's success in utilizing the registry, affording providers the opportunity to track the health and well-being of these patients.

Community needs ID Numbers: CN.5 and CN.10

New or enhanced initiative: This project is a new initiative for GPCH, and is also a new program for Hutchinson County. Currently, no registry for tracking COPD patients exists in the County, and this project will allow for much-needed patient outreach and disease management.

Related Category 3 Outcome Measures:
OD – 10: Quality of Life
Process measure: P2 (establish a baseline)
IT: 10.1: Demonstrate improvement in quality of life scores

GPCH chose this outcome because the goal of using the registry to manage the care for patients with COPD is to increase the quality of life for those patients and their families. COPD is a progressive disease, and with appropriate intervention it can be managed and allow for a higher quality and quantity of life for those affected by the chronic disease.

Relationship to Other Projects:
This project relates to Category 4 RD-1(4) (Potentially Preventable Admissions for COPD) and Category 4 RD-2(4) (30-day readmissions for COPD) because it seeks to assist COPD patients in managing their conditions prior to hospitalization and/or directly after hospitalization. A key component of providing chronic disease management is having the necessary data for engaging with the target patients organized and accessible.

Unique IDs: 197063401.4.1 and 197063401.4.2

Relationship to Other Performing Providers Projects in the RHP and Plan for Learning Collaborative:
Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the collaboration with Northwest Texas Healthcare System we will have an open forum on our website that will foster communication amongst our partners with related projects.

GPCH LLC, dba Golden Plains Community Hospital Collaboration with Northwest Texas Healthcare System

Golden Plains Community Hospital ("Golden Plains") and Northwest Texas Healthcare System ("Northwest") entered into a Collaboration Agreement in order to allow Golden Plains, as the Performing Provider, to undertake several transformative projects that will improve access and health care services to patients in the northeast portion of Region 12. Both Golden Plains and Northwest are private hospitals and entered into the collaboration agreement voluntarily. Although the local community served by Golden Plains is rural, there is a significant amount of industrial development in the area, including refineries, resulting in a heightened need for specialized healthcare not typically required in rural communities. Golden Plains is aware that patients in its community either don't have access to certain primary and specialty physician services or wait until significant problems arise and then seek care in Amarillo, where Northwest is located. Frequently, the delay in seeking care results in higher acuity diagnoses that require costly procedures. The primary objective of the collaboration is to implement projects that will reverse this trend, particularly in the most salient areas.

In order to encourage greater use of primary and preventative care services, Golden Plains intends to implement the following projects:

Project Identifier	Name of Project
197063401.1.1	Implement Use Chronic Disease Management Registry Functionalities
197063401.1.2	Expanding Primary Care Capacity (Internal Medicine)
197063401.1.3	Expanding Primary Care Capacity (OB/GYN)
197063401.2.2	Medical Homes

Golden Plains added a description of the transformative impact for these projects into both the project summaries and the project narratives. Golden Plains *may* seek advice from Northwest or physician practices and clinics as it seeks to implement these projects, but Golden Plains will be responsible for carrying out the full scope of the projects. Golden Plains continues to believe that its collaboration is fully consistent with the terms of Section 25(c)(iv) of the Funding and Mechanics Protocol. Finally, Golden Plains notes that nothing in Section 25(c)(iv) requires both parties to participate in the implementation of the DSRIP projects undertaken pursuant to a collaboration agreement.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Using a scoring system of 1-5, GPCH valued this project as follows: This project aims to use a relatively low cost measure (i.e. a registry) to affect big change (the coordination of care for a distinct population suffering from this chronic disease) in the health care and management offered to this population. The registry will allow GPCH to coordinate care for all COPD patients seeking care through GPCH and its clinic, thus Medicaid and uninsured will benefit from this program. The registry allows for coordinated, organized care delivery by making it easy for providers to track, remind, and maintain patient care. Finally, this project is relatively low cost to implement, but will yield savings by managing a disease that can easily lead to acute episodes requiring hospitalization and/or transfer to urban areas for acute care. Thus, it meets the goals of the Waiver in several manners.	**3**
Addresses Community Need(s)	This project addresses Community Needs Assessment number CN.5, which shows that there is a need in Region 12 for specialists to assist in the management of chronic lung disease because travel to urban areas is difficult. The registry is a step in the right direction for enabling physicians (including specialists) to manage COPD patients' conditions.	**2**
Project Scope/Size	This project will entail important community outreach, though the number of Hutchinson County residents directly impacted by the project is limited to the number of patients diagnosed with or at risk for COPD. The provision of care is expected to increase as patients receive additional reminders and care coordination as a result of the registry. In terms of the impact of monetary savings as a result of the project, Level 3 ED visit fees for professional and technical services for COPD patients can cost as much as $2000 per visit. A reduction of even 10% in the total number of COPD admissions (.10 x 1680 total COPD patients = 168 fewer admissions) would potentially yield a total ED savings of 168 * $2000/ visit = $336,000. The percentage of COPD patients that routinely become inpatients from the ED would be reduced as well. A COPD admission with a three day stay often results in service charges of at least $16,000. Using this registry we will be able to establish a baseline in the first year and determine savings by DY5.	**2**
Project Investment	This project will require significant human resources to assist in the development of the registry and training thereafter; the purchase of software through which to implement the registry and maintenance of the system over time; significant time and effort to collect data, create the registry, train the staff (estimated DYs2-3), and to increase enrollment (expected to happen during DYs 4-5).	**3**

197063401.1.1	*1.3.1*	*1.3.1.A-D*	*IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE REGISTRY FUNCTIONALITIES*
GPCH LLC Golden Plains Community Hospital			*197063401*
Related Category 3 Outcome Measure(s):	*197063401.3.1*	*IT-10.1*	**Quality of Life**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Implement a functional disease management registry to track COPD patients in Hutchinson County. **Metric 1 [P-4.1]:** Registry functionality is available in at least 50% of the Performing Provider's sites. Numerator: Number of sites with registry functionality Denominator: Total number of sites **Baseline/Goal:** 50% implementation of the registry **Data Source:** Documentation of adoption, installation, upgrade, interface or similar documentation of the registry **Milestone 1 Estimated Incentive Payment:** $391,466	**Milestone 2 [P-6]:** Conduct staff training on populating and using registry functions in order to track the patient touches for those with COPD in Hutchinson County. **Metric 1 P-6.1** Documentation of training programs and list of staff members trained on using the registry to track COPD patients in Hutchinson County **Baseline/Goal:** Train all GPCH clinical and hospital staff in the registry **Data Source:** HR or training program materials **Milestone 2 Estimated Incentive Payment:** $ 516,477	**Milestone 3 [I-15]:** 25% increase in the number of patients enrolled in the registry over DY3. **Metric 1 [I-15.1]:** Percentage of patients in the registry Numerator: Number of patients in registry Denominator: Number of patients assigned to this clinic for routine care (i.e., the clinic is the "medical home") **Baseline/Goal:** GPCH expects to register 500 patients in the registry, representing approximately 42% of the presently identified COPD patient population treated by GPCH through its hospital facility and clinics. **Data Source:** Registry list of patients **Milestone 3 Estimated Incentive Payment:** $307,597.80 **Milestone 4 [Additional Process Milestones]:** Assess efficacy of processes in place and recommend	**Milestone 5 4 [I-15]:** Increase the percentage of patients enrolled in the registry. **Metric 1 [I-15.1]:** Percentage of patients in the registry Numerator: Number of patients in registry Denominator: Number of patients assigned to this clinic for routine care (i.e., the clinic is the "medical home") **Goal:** GPCH expects to have 1000 patients registered in the registry, representing approximately 83% of the presently identified COPD patient population treated by GPCH through its hospital facility and clinics **Data Source:** Registry list of patients **Milestone 5 Estimated Incentive Payment:** $284,573 **Milestone 6 [Additional Process Milestones]:** Redesign the process in order to be more effective, incorporating learnings. **Metric 1:** Conduct analysis of options for

197063401.1.1	*1.3.1*	*1.3.1.A-D*	*IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE REGISTRY FUNCTIONALITIES*
GPCH LLC Golden Plains Community Hospital			*197063401*
Related Category 3 Outcome Measure(s):	***197063401.3.1***	***IT-10.1***	**Quality of Life**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
		process improvements to implement, if any **Metric 1:** Conduct analysis of successes and failures in implementing the registry, including increase in diagnoses, reduction in acuity for this population, and annual expansion of participants. **Baseline/Goal:** assess best practices and areas presenting key challenges going forward **Data source:** Report of findings **Milestone 4 Estimated Incentive Payment:** $307,597.80	expanding the patient population tracked through the disease registry. **Baseline/Goal:** Use DY4 analysis of the COPD registry successes and challenges, along with identified community needs, in order to identify opportunities for expanding the diseases tracked through the registry **Data source:** documentation of assessment and plans for expanding the registry **Milestone 6 Estimated Incentive Payment:** $284,573
Year 2 Estimated Milestone Bundle Amount: $ 391,467	Year 3 Estimated Milestone Bundle Amount: $ 516,477	Year 4 Estimated Milestone Bundle Amount: $ 615,196	Year 5 Estimated Milestone Bundle Amount: $ 569,146
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 2,092,285			

Project Option: 1.1.2 Expand Existing Primary Care Capacity (IM)
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.1.2

- **Provider:** GPCH is a 25-bed hospital in Borger, Texas serving an 895 square mile area and a population of approximately 21,000 (primary) and an additional 30,000 (tertiary). Although GPCH is located in a rural part of Texas, it provides a healthcare safety-net for the industrial community within its service area.
- **Intervention(s):** GPCH will recruit an Internal Medicine Physician ("IM") to the community to provide services previously not available at GPCH's clinics and to increase the clinics' capacity and its volume of patients.
- **Need for the project:** GPCH chose this project because Hutchinson County is a federally designated Primary Care Health Professional Shortage Area, meaning that there are patients who either do not have access to preventative or primary care, or only do so through the ED. Hutchinson County has a total of 11 primary care physicians for a population of 23,474 residents. Clearly there is a need for additional providers, such as an IM, to reduce the ratio of primary care physicians to patients from 1:2,134. This project will be performed in collaboration with Northwest Texas Healthcare System, a private hospital in Amarillo, as it is intended to effect transformation of the regional healthcare delivery by allowing rural residents to receive primary care in their community. The project is intended to prevent chronic disease and potentially preventable admissions for patients currently without preventative and primary care, which will benefit urban hospitals that often provide treatment to patients transferred from Hutchinson and surrounding counties with acute conditions.
- **Target population:** The target population for this project includes residents in Hutchinson County who do not have access to primary care currently and are eligible to receive care in the Borger clinics, and all patients currently accessing the Borger clinics who may have trouble accessing regular care because of limited appointment availability. In 2012, GPCH's clinics provided approximately 7,000 patient encounters to approximately 3,000 patients, 46% of which were Medicaid-eligible or uninsured. The current average delay for appointments at the clinic is 14 days. Presently, more than 10,325 residents in GPCH's catchment area are Medicaid-eligible or uninsured, and therefore could benefit from this project.
- **Category 1 or 2 expected patient benefits:** GPCH expects a 5% increase in the Borger clinic volume of appointments for patients in DY4 (estimated 350 additional appointments, of which approximately 161 are expected to be Medicaid/uninsured) and a 10 % increase in DY5 (estimated 700 additional appointments, of which approximately 322 are expected to be Medicaid/uninsured).

- **Category 3 outcomes:** IT-1.7: GPCH expects the increased availability of primary care services to help patients with chronic diseases better manage their conditions. One prevalent chronic disease in the community is high blood pressure, and GPCH expects an 8% increase in the number of patients with this condition whose blood pressure can be consistently controlled.

Project Option: 1.1.2 Expand Existing Primary Care Capacity (IM)
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.1.2

Project Components: 1.1.2.a-c

Project Description:

GPCH will recruit an Internal Medicine Physician ("IM") to the community to provide services previously not available at GPCH's clinic. This project will entail the core 1.1.2 project requirements:

a) Expand primary care clinic space: the IM will be located in the new clinic GPCH will be operating in the Borger community, with expanded square footage at a new facility – the IM will have his/her own space in which to treat the clinic's patients
b) Expand primary care clinic hours: the IM will be available to provide increased hours at the clinic for patients needing IM services; GPCH plans to offer an addition 1-2 hours of availability at the Borger clinic per weekday, and an additional 4 hours on Saturday
c) Expand primary care clinic staffing: there is currently not an IM at GPCH's clinic, so the project will be a 100% expansion

Project Goals: By DY5, GPCH intends to have increased access to primary care for Hutchinson County's residents through the extended hours during the week and the weekend hours, the expanded clinic space, and the additional primary care provider. The IM will allow GPCH to provide a higher level of primary care compared to the midlevel practitioners currently at the clinic.

- This project should allow for a 10% increase in the volume of appointments the clinic is able to provide (at the least). This increased access is expected to lead to better short- and long-term health outcomes for Hutchinson County's residents in the prevention and management of chronic conditions and/or acute episodes.
- Additionally, the increased access to primary care at the GPCH clinic will help patients monitor their blood pressure and implement preventative care designed to reduce the need for patients to travel over an hour to Amarillo for specialty care services and to prevent the onset of acute conditions requiring costly transfers to Amarillo for treatment.

Project Challenges and Issues: GPCH expects to confront the following challenges and issues, and to address them in the following manner:

1) Recruiting and retaining a qualified IM to treat patients in a rural community with for extended hours: GPCH will create incentives and a benefits package that will incentivize an IM to relocate to Borger.
2) Educating the community about the increase in access and level of care: GPCH will use social media, word-of-mouth and other innovative methods to make sure that patients know about the new clinic location, hours, and availability of an IM.
3) Assuring the IM has dedicated space in the clinic: GPCH will make sure to plan space within the new clinic it will dedicate to the IM providing primary care treatment

Five year expected outcome: As mentioned above, GPCH expects this project to result in a 10% (at minimum) increase in the volume of appointments provided at the Borger Clinic, and an increased ability for patients to manage chronic disease, such as hypertension, with local primary care support.

Relationship to Regional Goals: This project ties in with Region 12's goal to develop a local approach to health care delivery that leverages and improves existing programs and infrastructure, is responsive to patient needs in the Region (especially in rural areas, which is much of Region 12), and improves healthcare outcomes and patient satisfaction.

Starting Point/Baseline:
Currently the Borger clinics serve approximately 3,000 patients per year, and provide approximately 7,000 appointments per year.

Rationale:
GPCH chose this project because Hutchinson County is a federally designated Primary Care Health Professional Shortage Area, meaning that there are patients who either do not access preventative or primary care, or only do so through the ED. Hutchinson County has a total of 15 primary care physicians for a population of 23,474 residents. Clearly there is a need for additional providers, such as an IM, to reduce the ratio of physicians to patients from 1:47. In rural Region 12, 40% of respondents reported using a hospital or clinic in a town outside of the one they live in to obtain health care, and 4% of respondents reported using the ED when sick or in need of health care advice (data from RHP 12 Rural County report).

Core Requirements: GPCH's recruitment and retention of an IM will improve the ratio of primary care providers to residents in the County. GPCH's addition of expanded space will allow the IM to provide a higher volume and variety of primary care services on-site at the clinic. Finally, the extended hours provided by the clinic and the IM will allow Hutchinson County patients the option of accessing primary care after work and on the weekend, which is likely an impediment to accessing care now.

Milestones and Metrics: The milestones and metrics GPCH selected for this project address the infrastructure needs to implement this project in DYs 2-3 (expand the clinic, expand the hours, hire the IM) and address the sought-after improvement in DYs 4-5, which is to expand access to primary care for Borger residents, as reflected through an increase in the primary care clinic volume of 10%. The IM is trained to provide primary care and to provide care targeted for chronic adult diseases, which should enable the clinic to treat more patients and to provide more treatment options than it is currently able.

Community Needs Assessment Identification Numbers: This project ties to CN.1, CN.3, CN.4, and CN.5.

New Initiative: This project represents a new initiative for GPCH because it does not currently employ an internal medicine physician at the Borger Clinic.

Related Category 3 Outcome Measures:
OD – 1: Primary Care and Chronic Disease Management
Process measure: P2 (establish a baseline)
IT-1.7 Controlling high blood pressure

GPCH chose this Category 3 Outcome because the Region 12 CNA indicates that the rural areas of Region 12 have a high rate of death from heart disease (which is often linked to high blood pressure) and because 56% of households in Rural Region 12 reported high blood pressure being prevalent in their home. This is clearly a problem that needs to be addressed through patients receiving increased interventions from the health care system at early stages, such as the IM care that GPCH plans to implement at its clinic, and preventative care and chronic disease management are functions that the IM and clinic can fill.

Relationship to Other Projects:

Category 1 & 2 measures: This project ties to GPCH's project addressing the inefficient use of the ED at GPCH (2.8), in that access to primary care will potentially prevent patients from seeking non-emergent care at the ED in the first place. This project is related to GPCH's project adding an OB/Gyn, which will take place in the same clinic. Each provider (IM and OB/Gyn) will allow for increased clinic hours available in their specialty, will require additional treatment space in the new clinic location in order to treat a greater volume of patients, and each provider will constitute an additional staff member qualified to provide primary and preventative medical care in their respective specialties.

Category 4 population focused measures: This project ties to RD-1 in that expanded access to primary care should improve the number of potentially preventable admissions into the hospital. This should happen because patients will receive earlier interventions and preventative care from the IM. This project also ties to RD-4 in that patient satisfaction and medication management are both directly linked with patients having regular and easy access to primary care.

Relationship to Other Performing Providers Projects in the RHP and Plan for Learning Collaborative:
Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

GPCH LLC, dba Golden Plains Community Hospital Collaboration with Northwest Texas Healthcare System

Golden Plains Community Hospital ("Golden Plains") and Northwest Texas Healthcare System ("Northwest") entered into a Collaboration Agreement in order to allow Golden Plains, as the Performing Provider, to undertake several transformative projects that will improve access and health care services to patients in the northeast portion of Region 12. Both Golden Plains and Northwest are private hospitals and entered into the collaboration agreement voluntarily. Although the local community served by Golden Plains is rural, there is a significant amount of industrial development in the area, including refineries, resulting in a heightened need for specialized healthcare not typically required in rural communities. Golden Plains is aware that patients in its community either don't have access to certain primary and specialty physician services or wait until significant problems arise and then seek care in Amarillo, where Northwest is located. Frequently, the delay in seeking care results in higher acuity diagnoses that require costly procedures. The primary objective of the collaboration is to implement projects that will reverse this trend, particularly in the most salient areas.

In order to encourage greater use of primary and preventative care services, Golden Plains intends to implement the following projects:

Project Identifier	Name of Project
197063401.1.1	Implement Use Chronic Disease Management Registry Functionalities
197063401.1.2	Expanding Primary Care Capacity (Internal Medicine)
197063401.1.3	Expanding Primary Care Capacity (OB/GYN)
197063401.2.2	Medical Homes

Golden Plains added a description of the transformative impact for these projects into both the project summaries and the project narratives. Golden Plains *may* seek advice from Northwest or physician practices and clinics as it seeks to implement these projects, but Golden Plains will be responsible for carrying out the full scope of the projects. Golden Plains continues to believe that its collaboration is fully consistent with the terms of Section 25(c)(iv) of the Funding and Mechanics Protocol. Finally, Golden Plains notes that nothing in Section 25(c)(iv) requires both parties to participate in the implementation of the DSRIP projects undertaken pursuant to a collaboration agreement.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Using a scoring system of 1-5, GPCH valued this project as follows: The addition of an IM, extended hours, and expanded space at the Borger Clinic will allow GPCH to provide a higher level of care to the Borger community, while reducing costs through increasing access to preventative care meant to delay/prevent the onset of chronic diseases, and by reducing the escalation of existing patient conditions into an acute state through medication management and patient education provided by the IM. This project will assure that Medicaid and uninsured patients (who are the patients the clinic is designed to serve) can visit the clinic in a timelier manner (due to the additional provider and hours) and reduce/eliminate the need for patients to travel to urban centers, such as Amarillo, to obtain primary care or to address acute conditions resulting from a lack of primary care. The IM will be able to refer patients to specialists where necessary. Regular access to primary care is proven to lead to improved patient outcomes in the short- and long-term and to reduce system-wide costs, thus by expanding the clinic's hours, space, and providers, this project should lead to improved outcomes for patients and providers.	**5**
Addresses Community Need(s)	This project will address the following community needs: CN.1 (Severe primary care provider shortage, wait time, expense, lack of insurance, access to care), CN.3 (Poor insurance support or uninsured); CN.4 (High incidence of obesity, diabetes mellitus and heart disease); and CN.5 (Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult).	**5**
Project Scope/Size	• Outreach to the targeted population (social media, word of mouth) • Patient visits/encounters (10% increase for GPCH clinic) • Providers recruited/trained (1 IM) • Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations are estimated to be 9% over previous years baseline for the targeted population by earlier intervention.	**4**
Project Investment	• Human resources (recruitment and retention of IM) • Equipment purchase and maintenance (dedicating space and equipment for IM) • Legal and professional fees (IM salary and other clinic providers who work extended hours) • Time to implement (1 year to recruit and retain, 3 years to accomplish increase in patient volume) Value: 5 Total value of project/value of all GPCH's Pass 1 projects: 19/61	**5**

197063401.1.2	1.1.2	1.1.2.A-C	EXPAND EXISTING PRIMARY CARE CAPACITY	
GPCH LLC Golden Plains Community Hospital				197063401
Related Category 3 Outcome Measure(s):	197063401.3.2	IT-1.7	Primary Care and Chronic Disease Management: Controlling High Blood Pressure	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Relocate primary care clinic (to a larger, new cite in the community) **Metric 1 [P-1.1]:** Additional space in square footage and/or usable space for treating patients **Baseline/Goal:** Ability to treat more patients in the future due to increased space allowing for increased volume **Data Source:** Documentation showing GPCH's new clinical space: a lease or deed. **Milestone 1 Estimated Incentive Payment: $**371,893 **Milestone 2: P-5** Train/hire additional primary care provider (an IM) **Metric: P-5.1** Documentation of increased number of providers	**Milestone 3 [P-4]:** Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric 1 P-4.1** Increased number of hours at primary care clinic over baseline - **Baseline/Goal:** To increase clinic hours by at least 10 hours per week - GPCH will increase the Borger clinic's hours by 1-2 hours a day during the week, and 4 hours on Saturday, with the IM providing the additional hours. **Data Source:** Clinic documentation showing the clinic's schedule. **Milestone 3 Estimated Incentive Payment:** $ 981,307		**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Goal:** 5 % increase in clinic volume of patients with appointments over DY2 baseline number of approximately 7000 appointments (estimated 350 additional appts.) **Data Source:** Clinic's EHR showing the appointment schedule and residency of the patients **Milestone 4 Estimated Incentive Payment:** $1,168,872	**Milestone 5 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Goal:** 10 % increase in clinic volume of patients with appointments who reside in Hutchinson County over DY2 baseline number of approximately 7000 appointments (estimated 700 additional appts.) **Data Source:** Clinic's EHR, showing the appointment schedule and residency of the patients **Milestone 5 Estimated Incentive Payment:** $1,081,377 *Conducting quality improvement would not be an appropriate measure*

197063401.1.2	1.1.2	1.1.2.A-C	EXPAND EXISTING PRIMARY CARE CAPACITY	
GPCH LLC Golden Plains Community Hospital				197063401
Related Category 3 Outcome Measure(s):	**197063401.3.2**	**IT-1.7**	**Primary Care and Chronic Disease Management: Controlling High Blood Pressure**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: To hire a physician trained in Internal Medicine **Data Source:** Evidence of hiring from HR, including an employment contract and/or the physician's clinic schedule. **Milestone 2 Estimated Incentive Payment:** $371,893				*for this project, as it involves hiring a new provider and increasing volume, not creating a new process.*
Year 2 Estimated Milestone Bundle Amount: $ 743,786	Year 3 Estimated Milestone Bundle Amount: $ 981,307		Year 4 Estimated Milestone Bundle Amount: $ 1,168,872	Year 5 Estimated Milestone Bundle Amount: $ 1,081,377
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 3,975,342				

Project Option: 1.1.2 Expand Existing Primary Care Capacity (OB/GYN)
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.1.3

- **Provider:** GPCH is a 25-bed hospital in Borger, Texas serving an 895 square mile area and a population of approximately 21,000 (primary) and an additional 30,000 (tertiary). Although GPCH is located in a rural part of Texas, the hospital provides a healthcare safety-net for the industrial community within its service area.
- **Intervention(s):** GPCH will recruit an OB/Gyn to the community to provide services at GPCH's Borger clinic, in order to decrease pre-term births and the transfer of women and/or infants to Amarillo hospitals for at-risk pregnancies.
- **Need for the project:** Although GPCH makes obstetric services available to hospital patients, the hospital does not currently have an OB/Gyn and instead relies on family practitioners to treat indigent patients in the community. Of the approximately 7000 appointments provided at GPCH's clinics in 2012 (46% of which were Medicaid/self-pay), none were scheduled for gynecological/obstetric services. The only local provider offering regular OB/Gyn appointments was an independent family practice physician, who could not provide specialized care for women with complex obstetric or gynecological needs. GPCH believes that increased, localized access to an OB/Gyn will allow GPCH to create a positive impact on the health outcomes for female Hutchinson County residents and infants born to Hutchinson County residents. This project will be performed in collaboration with Northwest Texas Healthcare System, a private hospital in Amarillo, as it is intended to effect transformation of the regional healthcare delivery by allowing rural residents to receive primary care in their community, particularly for those females with at-risk pregnancies. The project is intended to prevent costly transfers from GPCH to Amarillo for pre-natal complications, high-risk deliveries, and NICU stays for infants whose conditions may have been caused by a lack of access to regular pre-natal care. The average stay in the Northwest NICU is 15 days, and the average cost per day is estimated to be $10,000, meaning that this project can save $150,000 for the Region for each NICU stay it prevents due to increased and improved pre-natal care locally.
- **Target population:** The target population of this project is women in Hutchinson County and the surrounding community who require gynecological and/or obstetric services, and who do not currently have regular access to OB/Gyn specialty services in the local community. Hutchinson County is comprised of 50% women, and has a 24% rate of uninsured. Patients who are included in both of those categories are expected to benefit most from this project because the clinic caters to this population. GPCH treated approximately 12,000 unique patients in 2012 through its hospital and area clinics, meaning that

approximately 6,000 of those patients were women who could currently or at some point in the future benefit from the addition the OB/Gyn into the community (both at the hospital and in the clinic). GPCH estimates there are at least 200-300 pregnant women in its catchment area who currently have to drive over 60 miles to obtain specialized prenatal care because there is no OB/GYN specialty physician in Hutchinson County, and no hospital in the surrounding counties of Carson and Hansford. Additionally, upon reviewing Texas State Birth numbers by GPCH's catchment counties, fewer than half of the births to GPCH residents take place at GPCH. Providing specialty prenatal care for the at-risk population will reduce pre-term deliveries and costly NICU care associated with this population, many of which are Medicaid or uninsured. Additionally, it will allow women to deliver their children closer to home and their families.

- **Category 1 or 2 expected patient benefits:** GPCH seeks to increase the clinic's patient volume of appointments provided to women seeking OB/Gyn services by 25% from DY3 baseline in DY4, and by 20% from DY4's volume in DY5.

- **Category 3 outcomes:** IT 6.1 – By DY5, GPCH expects to improve patient satisfaction scores concerning female patients' access to timely OB/Gyn-related care, appointments, and information at GPCH's clinic by 6% over the baseline.

Project Option: 1.1.2 Expand Existing Primary Care Capacity (OB/GYN)
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.1.3

Project Components: 1.1.2.a-c

Project Description:
GPCH will recruit an OB/Gyn to the community to provide services at GPCH's Borger clinic, in order to decrease pre-term births and transfer of women and/or infants to Amarillo hospitals. Many babies, and by extension their families, are transferred to Amarillo for pre-natal care, high risk deliveries and NICU stays that cannot be provided locally. Instead, these babies could be delivered here, closer to home; thus the goal is to recruit a full time OB/GYN provider to provide close to home quality of care, and as a result, deliver more infants in Hutchinson County.

This project will entail the core 1.1.2 project requirements:

a) Expand primary care clinic space: the OB/Gyn will be located in the new clinic that GPCH will be operating in Borger, with expanded square footage at a nicer facility – the OB/Gyn will have his/her own space in which to treat patients

b) Expand primary care clinic hours: the OB/Gyn will be available to provide increased hours at the clinic for patients needing OB/Gyn services; GPCH plans for an addition 1-2 hours of availability per weekday, and an addition 4 hours on Saturday

c) Expand primary care clinic staffing: The clinic will now include an OB/Gyn physician, which it did not before.

Project Goals: The goal behind adding an OB/Gyn to the clinic is to decrease referrals to Amarillo for NICU care, to provide more regular and specialized OB/Gyn care locally, and for more Hutchinson County mothers to deliver at term. Historical evidence shows that there are lower costs to the healthcare system for infants born at term, increased patient satisfaction and better health outcomes.

- GPCH seeks to increase the clinic's patient volume of appointments for women of reproductive age by at least 25% over DY3's baseline DY4 and by an additional 20% over DY4's volume in DY5.

Project Challenges: GPCH expects to confront the following challenges and address them in the following manner:

1) Recruiting and retaining a qualified OB/Gyn to treat patients in a rural community with for extended hours: GPCH will create incentives and a benefits package that will incentivize an IM to relocate to Borger.

2) Educating the community about the increase in access: GPCH will use social media, word-of-mouth and other innovative methods to make sure that patients know about the new clinic location, hours, and availability of an OB/Gyn, so they will be less inclined to travel outside Hutchinson County for care.

3) Assuring the OB/Gyn has dedicated space in the clinic: GPCH will make sure to plan space within the new clinic dedicated to the OB/Gyn providing primary care treatment

5-year Expected Outcome: The five year expected outcome of this project is to reduce the number of women traveling and/or transferred to Amarillo for routine and/or specialized OB/Gyn care (and to provide such care to those women who currently do not seek such care because it is not available locally). This is expected to lead to better health outcomes for local women of reproductive age and newborn infants, and to increase the number of deliveries close to women's homes and families.

Relationship to Regional Goals: This project seeks to improve the delivery of necessary healthcare services that are lacking in rural areas of Region 12, which will reduce the burden on the urban providers and improve patient healthcare outcomes and satisfaction throughout the Region.

Starting Point/Baseline:

As of February 2013, the OB/Gyn has been hired and has treated approximately 80 unique patients, and expects an average of 4 visits per year for each patient. The OB/Gyn expects to deliver approximately 50 pregnant women over the next three months.

Rationale:

GPCH chose this project because in Region 12, 8.4% of births result in low-birth weights. In Rural Region 12 in 2003, there were 410 teen pregnancies, which comprised 2% of the teen pregnancies statewide that same year, even though Rural Region 12 is only 1.5% of the state's population. Additionally, Rural Region 12 had 1.8% of the total infant deaths in August 2004, which is 1.8% of the total statewide for the same reporting period (even though Rural Region 12 is only 1.5% of the state population). High-risk and teenage pregnancies could likely be reduced by easier access to an OB/Gyn in the community and/or at least lead to better health outcomes. Infant deaths could possibly be prevented by earlier and increased access to prenatal care for women in the community.

Additionally, Hutchinson County is a federally designated Primary Care Health Professional Shortage Area, meaning that there are patients who either do not access preventative or primary care, or only do so through the ED. Hutchinson County has a total of 15 primary care physicians for a population of 23,474 residents.

Core components: GPCH's recruitment and retention of an OB/Gyn will improve the ratio of primary care providers to residents in the County, with specific application to the women of Hutchinson County. GPCH's addition of expanded space will allow the OB/Gyn to provide a higher volume and variety of primary care services to women of reproductive age on-site at the clinic. Finally, the extended hours provided by the clinic and the OB/Gyn will allow Hutchinson County women the option of accessing primary care after work and on the weekend, which is likely an impediment to accessing care now.

The milestones and metrics GPCH selected for this project address the infrastructure needs to implement this project in DYs 2-3 (relocate the clinic, expand the hours, hire the OB/Gyn) and address the sought-after improvement in DYs 4-5, which is to expand access to primary care for Hutchinson County women of reproductive age, as reflected through an increase in the primary care clinic volume of appointments for those patients.

Community Needs Identification Numbers: The addition of the OB/Gyn to the Borger Clinic should address the following Community Needs: CN.1, CN.7, CN.12, CN.14

New or Enhanced Initiative: Currently, there is not an OB/Gyn physician in the Borger clinic, so this project represents a new initiative for GPCH, which will enhance GPCH's provision of healthcare locally.

Related Category 3 Outcome Measures:

OD 6: Patient Satisfaction
Process measure: P2 (establish a baseline)
IT-6.1(1): Patient rating of timely access to appointments, care, and information

GPCH chose this outcome because one goal behind increasing women's local access to an OB/Gyn in the local community is to improve patient satisfaction with the ability to access care in a timely manner before, during, and after pregnancy. Pregnancies require regular appointments, and especially for first-time mothers, access to a variety of healthcare related information. Additionally, many women require appointments and information when attempting to become pregnant, and need additional follow-up appointments and care post-partum. The local OB/Gyn will be able to provide these services, as well as regular gynecological services, which GPCH anticipates will increase GPCH/Borger clinic patients' satisfaction with their access to services.

Relationship to Other Projects: This project ties to RD:4 in Category 4, in that it is expected to improve patient satisfaction for women residing in Hutchinson County who are of reproductive age by giving them increased access to a local practitioner trained to provide gynecological and obstetric services. This project also ties with GPCH's project to add an Internal Medicine physician to its community clinics, in that both projects are meant to expand primary care access for the indigent population in GPCH's catchment area. Both the OB/Gyn and the IM physician will provide services in the new Borger clinic space, which will be expanded to allow treatment space for both providers. Each of the physicians will provide additional hours of service above what the clinic provides now, and will increase the number of available appointments to the population seeking their care.

Relationship to Other Performing Providers Projects in the RHP and Plan for Learning Collaborative:
Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

GPCH LLC, dba Golden Plains Community Hospital Collaboration with Northwest Texas Healthcare System

Golden Plains Community Hospital ("Golden Plains") and Northwest Texas Healthcare System ("Northwest") entered into a Collaboration Agreement in order to allow Golden Plains, as the Performing Provider, to undertake several transformative projects

that will improve access and health care services to patients in the northeast portion of Region 12. Both Golden Plains and Northwest are private hospitals and entered into the collaboration agreement voluntarily. Although the local community served by Golden Plains is rural, there is a significant amount of industrial development in the area, including refineries, resulting in a heightened need for specialized healthcare not typically required in rural communities. Golden Plains is aware that patients in its community either don't have access to certain primary and specialty physician services or wait until significant problems arise and then seek care in Amarillo, where Northwest is located. Frequently, the delay in seeking care results in higher acuity diagnoses that require costly procedures. The primary objective of the collaboration is to implement projects that will reverse this trend, particularly in the most salient areas.

In order to encourage greater use of primary and preventative care services, Golden Plains intends to implement the following projects:

Project Identifier	**Name of Project**
197063401.1.1	Implement Use Chronic Disease Management Registry Functionalities
197063401.1.2	Expanding Primary Care Capacity (Internal Medicine)
197063401.1.3	Expanding Primary Care Capacity (OB/GYN)
197063401.2.2	Medical Homes

Golden Plains added a description of the transformative impact for these projects into both the project summaries and the project narratives. Golden Plains *may* seek advice from Northwest or physician practices and clinics as it seeks to implement these projects, but Golden Plains will be responsible for carrying out the full scope of the projects. Golden Plains continues to believe that its collaboration is fully consistent with the terms of Section 25(c)(iv) of the Funding and Mechanics Protocol. Finally, Golden Plains notes that nothing in Section 25(c)(iv) requires both parties to participate in the implementation of the DSRIP projects undertaken pursuant to a collaboration agreement.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Using a scoring system of 1-5, GPCH valued this project as follows: The addition of an OB/Gyn, extended Borger clinic hours, and expanded space will allow GPCH to provide a higher level of care to the women in Hutchinson County. This higher level of care includes access to preventative care and management of pregnancy and conditions/diseases that the OB/Gyn is trained to treat. This higher level of care is intended to prevent acute gynecological and obstetric episodes requiring hospitalization. The Borger clinic, where the OB/Gyn will be housed, is designed to treat the Medicaid and uninsured population of Hutchinson County, and will provide previously unavailable services to the Hutchinson County community. The OB/Gyn will coordinate with patients' other primary care providers at the clinic and area specialists to assure that patients receive a continuity of care, especially during pregnancy. Ultimately, preventing the transfer of patients to Amarillo for delivery and other conditions related to pregnancy will improve patient satisfaction, quality of life, and overall health, while also reducing costs.	**5**
Addresses Community Need(s)	This project will address the following Region 12 Community Needs: CN.1, CN.7, CN.12, and CN.14. On a more local level, the project addresses the healthcare needs of all women within the catchment area of the clinic, and will allow increased and more efficient access to primary, preventative, and specialty care (when needed).	**4**
Project Scope/Size	This project will entail: • Outreach to the targeted population by word of mouth, social media/internet, and posters around the community. • The number of patient visits/encounters at the Borger Clinic is expected to increase by 10%, with regard to its unique patient volume of women needed gynecological and obstetric services. • The project will entail recruiting and training one physician.	**3**
Project Investment	GPCH expects this project to require the following investments: •Human resources – GPCH will need to invest time and effort to recruit and train a qualified OB/Gyn provider who is willing to live and work in a rural community. •Equipment purchase and maintenance – GPCH will need to identify and/or purchase the necessary equipment for performing annual exams, sonograms, and other standard gynecological and obstetric services. •Time to implement – GPCH expects the following: 1 year to recruit the provider; 3 years to increase the clinic volume of unique patients seen (women seeking OB/Gyn services) by 10%. Total value of this project/all GPCH Category 1 & 2 projects: 17/61	**5**

197063401.1.3	1.1.2	1.1.2.A-C	EXPAND EXISTING PRIMARY CARE CAPACITY	
GPCH LLC Golden Plains Community Hospital				197063401
Related Category 3 Outcome Measure(s):	197063401.3.3	IT-6.1	Percent Improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Train/hire additional primary care provider (OB/Gyn) to work in the expanded clinic space **Metric 1 [P-5.1]:** Documentation of increased number of providers (1) **Baseline/Goal:** To hire a physician trained in obstetrics and gynecology **Data Source:** The OB/Gyn's contract and/or clinic schedule **Milestone 1 Estimated Incentive Payment: $ 665,493**	**Milestone 2 [P-4]:** Expand the hours of the primary care clinic, including OB/Gyn evening and/or weekend hours - 1-2 hours of OB/Gyn availability on weekdays, 4 hours on Saturday. **Metric 1 P-4.1** Increased number of hours at clinic performed by the OB/Gyn over baseline - at least 10 hours per week of after **Baseline/Goal:** 10 after hours/weekend hours of OB/Gyn services at the clinic **Data Source:** Clinic documentation of the OB/Gyn's schedule during the measurement year **Milestone 2 Estimated Incentive Payment:** $ 878,011		**Milestone 3 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for Hutchinson County women seeking obstetric/gynecological services **Metric 1 [I-12.2]:** increased number of unique patients (Hutchinson County residents of child-bearing age and pregnant women) seen at the clinic **Baseline/Goal:** By the end of DY3, GPCH expects the OB/Gyn to have provided at least 400 appointments. GPCH is targeting a 25% increase over that baseline (approximately 100 additional visits for OB/Gyn services, for a total of 500 OB/Gyn appointments locally) **Data Source:** Electronic health records showing how many patients came to the clinic for appointments with the OB/Gyn, also verifying the patients' county of residence **Milestone 3 Estimated Incentive Payment:** $1,045,833	**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking obstetric/gynecological services **Metric 1 [I-12.2]:** increased number of unique patients (women of child-bearing age and specifically pregnant women) seen at the clinic **Goal:** By the end of DY4, GPCH expects the OB/Gyn to have provided at least 500 appointments. GPCH is targeting a 20% increase over that DY4 target (approximately 100 additional visits for OB/Gyn services, for a total of 600 OB/Gyn appointments locally) **Data Source:** Electronic health records showing how many patients came to the clinic for appointments with the OB/Gyn, also verifying the patients' county of residence **Milestone 4 Estimated Incentive Payment:** $967,548

197063401.1.3	1.1.2	1.1.2.A-C	EXPAND EXISTING PRIMARY CARE CAPACITY	
GPCH LLC Golden Plains Community Hospital				197063401
Related Category 3 Outcome Measure(s):	**197063401.3.3**	**IT-6.1**	**Percent Improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $ 665,493	Year 3 Estimated Milestone Bundle Amount: $ 878,011		Year 4 Estimated Milestone Bundle Amount: $ 1,045,833	Year 5 Estimated Milestone Bundle Amount: $ 967,548
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 3,556,885			Conducting a quality improvement measure would not be appropriate for this project as it does not include the implementation of a new process.	

Project Option: 1.9.2 Improve access to specialty care (OB/GYN)
Performing Provider Name/TPI: Hansford County Hospital District/094117105
Unique Project ID: 094117105.1.1
Project Components: 1.9.2.a-d

Project Summary

- **Provider:** Hansford County Hospital District operates a 14 bed Critical Access Hospital as well as a Rural Health Clinic. We serve all of Hansford County which has a population of approximately 5,500.
- **Interventions:** This project will create an OB/GYN specialty clinic to provide OB/GYN services to female patients in Hansford County.
- **Need for the Project:** Currently Hansford County residents have to drive 45 – 100 miles to receive OB/GYN care. Many of our lower income residents fail to receive the appropriate level of prenatal care during their pregnancies which can lead to complications that could have been prevented with the right care at the right time.
- **Target population:** The target population is our lower income and Medicaid patients that are not receiving the prenatal care they need. Hansford County had 112 births in 2012 and of those births, there were 0 prenatal visits at HCHD. For DY2 we will use 2012 as a baseline and target 10% of the total # of births, or 11 mothers. We then estimated that for a normal pregnancy the average mother has 10 visits, giving us approximately 110 visits. We plan to increase DY3 visits to 132 , DY4 visits to 158,and DY5 visits to 190. We estimate that Medicaid and uninsured patients will comprise of 25% of these visits.
- **Category 1 expected patient benefits:** The project seeks to steadily improve the number of patients being seen in the OB/GYN clinic from DY 2 through DY 5. By offering these services closer to home we hope to decrease the number of preventable complications during pregnancy.
- **Category 3 outcomes:** IT-6.1 Percent improvement over baseline of patient's satisfaction scores in Category 3. It is expected to improve patient satisfaction for women residing in Hansford County who are of reproductive age by giving them increased access to a local practitioner trained to provide gynecological and obstetric services.

Project Option: 1.9.2 Improve access to specialty care (OB/GYN)
Performing Provider Name/TPI: Hansford County Hospital District/094117105

Unique Project ID: 094117105.1.1
Project Components: 1.9.2.a-d

Project Description:

Hansford County Hospital District proposes to improve access to specialty care (OB/GYN) by increasing the number of specialty clinic locations and standardizing the referral process.

Currently Hansford County Hospital District is the main provider of healthcare in Hansford County. Hansford County has seen its population grow by 4.5% over the last ten years creating a greater need to improve access to specialty care to our county residents. This project will consist of increasing available specialty clinic space as well as standardizing the referral process. Our goal is to create a small, 2 exam room specialty clinic. Currently Hansford county residents have to travel 100 miles to receive specialty care. This project will address this by creating space for specialist to hold clinic, thus keeping our patients from making the long trip to Amarillo. The second component of this project is to standardize the referral process at HCHD. We plan to do this by implementing an online/computerized referral system and by creating guidelines and technology for referrals and consultations into selected medical specialties.

This project will target the low income, uninsured and minority populations in our community. In Hansford County, approximately 13.3% of the population is below the poverty line. Approximately 33% of our county residents are uninsured. These populations present a challenge to providing quality health care in our community. Adding an OBGYN Specialty clinic will accommodate the needs of this population so they receive the right care at the right time and in the right setting. Expanding specialty care will also provide an opportunity for increased preventative healthcare and improve health outcomes.

Target Zip Codes:

79081	79040 79062			

Goals and Relationship to Regional Goals:

The goal of this project is to ensure patients have access to specialty care when they need it. Having access to specialty care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to specialty care, Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED

Project Goals:

- Increase the number of specialty clinics 0 to 1
- Increase specialty clinic hours
- Recruit specialist to work in specialty clinic
- Obtain an online/computerized referral system

This project meets the following regional goals:

- This project works to transform health care delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. This project specifically addresses community needs identification # CN.1, which is a critical item identified in RHP 12's needs assessment.

Challenges:

One of the main challenges our residents have with accessing specialty care is availability of specialist and available hours. By increasing the availability of our providers and increasing available clinic hours patients will have the access to specialty care at the right time and right place, thus decreasing unnecessary ER visits and increasing patient compliance.

5-Year Expected Outcome for Provider and Patients:

HCHD expects to see increased specialty clinic visits starting in DY2. Providers expect to see increased patient load as well as increased patient compliance as access to specialty care increases. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:

Currently HCHD does not have a space for a specialty clinic. Therefore our baseline for DY2 is 0 specialty clinics and 0 specialist visits.

Rationale:

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the appropriate care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing specialty care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services are available. By enhancing access points, available appointment times, patient awareness of available services and overall specialty care capacity, patients and their families will align themselves with the health care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

One of our milestones for DY2 is to Launch/expand a specialty care clinic. Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. Additionally, specialty care clinics allow for enhanced care coordination for those patients requiring intensive specialty services. Another milestone for DY 2 is to expand the ambulatory care medical specialties referral management department and related functions. A robust referral management department or clinic function can ensure that referrals are processed, reviewed and the patient's clinical issue addressed in a timely manner.

Project Components:

Through the expansion of specialty care capacity, we propose to meet all required project components.

a) *Increase service availability with extended hours*-Currently there are not any specialist that see patients in Hansford County. We plan to recruit specialist to our area and to open the specialty clinic various days throughout the week.

b) Increase number of specialty clinic locations – We propose to increase our available specialty clinic from 0 to 1

c) *Implement transparent, standardized referrals across the system.*- Clinic leadership will demo and select a computerized referral system to be utilized throughout the primary care clinic. They will also develop standard policies and procedures for referrals

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a

broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations

Unique community need identification numbers the project addresses:

- CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently to access specialty care patients must drive 100 miles to Amarillo. The initiative will improve access for targeted patients while helping the system reach capacity for treating our patients.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction:
IT-6.1 Percent improvement over baseline of patient's satisfaction scores.

Reasons/rationale for selecting the outcome measures:

We selected OD-6 Patient Satisfaction as our related category 3 project. The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patient's perspectives on hospital care. HCHD intends to use the CAHPS Clinician and Groups visit survey for both adults and pediatrics. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Relationship to other Projects:

This project ties IT-6.1 Percent improvement over baseline of patient's satisfaction scores in Category 3, in that it is expected to improve patient satisfaction for women residing in Hansford County who are of reproductive age by giving them increased access to a local practitioner trained to provide gynecological and obstetric services.

This project also ties into our Pass 3b project, Expanding access to primary care. Our pass 3b project includes building new primary care clinic space for our primary care providers. This project will enhance the pass 3b project by adding additional specialty clinic space for an OBGYN to see patients.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project will ensure patients have access to specialty care when they need it. Having access to specialty care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to specialty care, Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED.	**5**
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	**3**
Project Scope/Size	While there is opportunity to increase the total number of visits, the population of Hansford County is fairly small thus reducing the potential for significant savings as a result of this project.	**3**
Project Investment	The investment required for this project is high. The cost of adding exam space and recruiting additional staff an providers if very significant. It will take several years to achieve all the goals outlined in this project.	**5**

094117105.1.1	1.9.2	1.9.2.a-d	Increase access to specialty care (OB/GYN)
Hansford County Hospital District		**094117105**	
Related Category 3 Outcome Measure(s):	**094117105.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-11. Milestone 1: Launch/expand a specialty care clinic **Metric 1: P-11.1.** Establish/expand specialty care clinics **Baseline/Goal:** Baseline of 0 specialty clinics. Goal is to increase to 1 specialty clinic **Data Source**: Documentation of new/expanded specialty care clinic plans **Estimated Milestone 1 Incentive Payment:** $14,053 **P-4. Milestone 2:** Expand the ambulatory care medical specialties referral management department and related functions **Metric 2: P-4.1** Referral Management system utilization . **Data Source:** Reports generated by the Referral Management system, EHR and other administrative reports as needed **Baseline/Goal:**0/50% **P-4.2. Metric:** Policy development for and staff training for utilization of	I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source Baseline/Goal:110/ 132 OBGYN visits Data Source:Clinic Documentation Estimated Milestone 4 Incentive Payment: $48,867	I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source Baseline/Goal:132/ 158 OBGYN visits Data Source:Clinic Documentation Estimated Milestone 5 Incentive Payment: $49,372	I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source Baseline/Goal:158/ 190 OBGYN visits Data Source:Clinic Documentation Estimated Milestone 6 Incentive Payment: $42,301

094117105.1.1	**1.9.2**	**1.9.2.a-d**	**Increase access to specialty care (OB/GYN)**
Hansford County Hospital District		**094117105**	
Related Category 3 Outcome Measure(s):	**094117105.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Referral Management system b. Data Source: Number of FTEs/Written description for process of managing referrals into medical specialties Baseline/Goal:0/100% Estimated Milestone 2 Incentive Payment: $14,053 I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source Baseline/Goal:0/ 110 OBGYN visits Estimated Milestone 3 Incentive Payment: $14,053			
DY 2 Estimated Milestone Bundle Amount: *$42,159*	**DY 3 Estimated Milestone Bundle Amount:** $48,867	**DY4 Estimated Milestone Bundle Amount:** $49,372	**DY5 Estimated Milestone Bundle Amount:** *$42,301*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *$182,699*			

Project Option: 1.1.2 Expand Existing Primary Care Capacity
Performing Provider Name/TPI: Hansford County Hospital District/094117105
Unique Project ID: 094117105.1.3– **"PASS 3b"**
Project Components: 1.1.2.a-c

Project Summary

- **Provider:** Hansford County Hospital District operates a 14 bed Critical Access Hospital as well as a Rural Health Clinic. We serve all of Hansford County which has a population of approximately 5,500.
- **Interventions:** This project will create more exam rooms for primary care providers to see patients in Hansford County. Currently all exam rooms are spread out over 3 buildings. HCHD proposes to build a new clinic that will house all providers and will have 20 exam rooms. It will also allow us to expand our hours to include weekends
- **Need for the Project:** Currently Hansford County Hospital District only has 13 exam room available to our primary care providers. This limits the number of patients our providers are able to see, thus causing some patients to receive delayed care.
- **Target population:** This project will target the low income, uninsured and minority populations in our community. Approximately 33% of our county residents are uninsured. HCHD will employ a new provider to work weekends as well as increase the number of exam rooms. As such, the provider will see all payor classes in his/her practice (all patients regardless of their ability to pay). Based on a 40 hour a week practice of 2,500 visits, we expect the weekend provider (12 hours/weekend) to see 750 patients per year. Based on the HCHD payor mix, we estimate the practice could see 210 Medicaid and Uninsured/indigent patients per year.

- **Category 1 expected patient benefits:** The project seeks to steadily improve the number of Medicaid and uninsured/indigent patients being seen in the Rural Health Clinic from 4,260 to 4,470 beginning in DY3, to 4,695 in DY4, and 4,930 in DY5. By increasing our capacity for primary care visits we hope to decrease the number of unnecessary ER visits.

- **Category 3 outcomes:** IT-6.1 Percent improvement over baseline of patient's satisfaction scores in Category 3. It is expected to improve patient satisfaction for residents in Hansford County by increasing the available hours and capacity of the Rural Health Clinic. HCHD will utilize the CAHPS Clinician and Group Survey for both adults and pediatrics. This will enable patients to receive the right care at the right time.

Project Option: 1.1.2 Expand Existing Primary Care Capacity
Performing Provider Name/TPI: Hansford County Hospital District/094117105
Unique Project ID: 094117105.1.3 – **"PASS 3b"**
Project Components: 1.1.2.a-c

Project Description:

Hansford County Hospital District proposes to expand primary care capacity by expanding available clinic exam rooms and by expanding clinic hours.

Currently Hansford County Hospital District is the main provider of healthcare in Hansford County. Hansford County has seen its population grow by 4.5% over the last ten years creating a greater need to expand primary care capacity to our county residents. This project will consist of increasing the total number of available exam rooms. Our goal is to go from 13 exam rooms to 20 exam rooms. We propose to do this by constructing a new clinic that will house all of our providers and will have 20 exam rooms..Currently our providers are challenged with seeing patients in their limited space. This project will address this by giving each provider up to 5 of their own, dedicated exam space thus allowing them to see more patients per day. An additional goal of the project is to increase the number of hours the primary clinic is open per week. Currently the clinic is open M-F 9 a.m to 5 p.m. We expect to increase our available hours in DY 3. This leads to the third component of this project, recruiting additional staff and providers to work extended hours. HCHD currently has 3 full-time physicians and 1 part time PA working in the clinic. In order to meet our goals and objectives HCHD will need to recruit additional providers and staff to work during the extended clinic hours. We anticipate increasing our staff in DY2

This project will target the low income, uninsured and minority populations in our community. Approximately 33% of our county residents are uninsured. These populations present a challenge to providing quality health care in our community. Individuals from these various groups often have multiple chronic conditions, prevalent in our community - diabetes. Without regular primary care, these conditions become acute episodes putting these patients at risk for disability and premature death. Adding a primary care provider (PCP) will accommodate the needs of this population so they receive the right care at the right time and in the right setting. Expanding primary care capacity will also provide an opportunity for increased preventative healthcare and improve health outcomes.

Target Zip Codes:

79081 79040 79062

Goals and Relationship to Regional Goals:

The goal of this project is to ensure patients have access to primary care when they need it. Having access to primary care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to primary care, Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED

Project Goals:

- Increase the number of clinic exam rooms from 13 to 20
- Increase clinic hours to include evenings and weekends
- Recruit additional staff to work expanded hours

This project meets the following regional goals:

- This project works to transform health care delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. This project specifically addresses community needs identification # CN.1, which is a critical item identified in RHP 12's needs assessment.

Challenges:

One of the main challenges our residents have with accessing primary care is availability of primary care providers and available hours. By increasing the availability of our providers and increasing available clinic hours patients will have the access to primary care at the right time and right place, thus decreasing unnecessary ER visits and increasing patient compliance.

5-Year Expected Outcome for Provider and Patients:

HCHD expects to see increased clinic visits starting in DY 3. Providers expect to see increased patient load as well as increased patient compliance as access to primary care increases. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:

Currently HCHD has 13 available clinic exam rooms. Therefore our baseline for DY2 is 13 exam rooms. HCHD's clinic is open 35 hours/ week. Therefore our baseline for clinic hours is 35 hours/week

Rationale:

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services.

The project options chosen by HCHD are very critical to its community and its ability to provide services needed by the community. In project 1.1.2, HCHD will expand the clinic space by building a new clinic, and it will increase its primary care service hours by opening the clinic on weekends. In doing this, HCHD will show process milestones of P-1, Establish/Expand existing/relocate primary care clinic, P-4, Expand the hours of the primary clinic where they are currently serving patients from 9-5 M-F.

Project Components:

Through the expansion of primary care capacity, we propose to meet all required project components.

a) *Expand primary care clinic space* - We will increase the number of available exam rooms from 13 to 20 thus giving providers the capability to see more patients throughout the day.

b) *Expand primary care clinic hours*- HCHD's clinics are currently open M-F 9 a.m to 5 p.m. We propose to expand clinic hours to include evenings 3 days a week increasing our hours by 6 per week.

c) *Expand primary care clinic staffing* - The third and final component of this project is the expansion of primary clinic staffing. This is an especially difficult component to complete. Finding willing and capable staff and providers to work evening and weekend hours is difficult. The goal of this project is to recruit additional staff and providers to cover the expanded hours

Unique community need identification numbers the project addresses:

- CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently access to primary care is limited to M-F 9 a.m. to 5 p.m. and is limited to the number of available exam rooms. The initiative will improve access for targeted patients while helping the system reach capacity for treating primary care patients.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction:
IT-6.1 Percent improvement over baseline of patient's satisfaction scores.

Reasons/rationale for selecting the outcome measures:

We selected OD-6 Patient Satisfaction as our related category 3 project. The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patient's perspectives on care. HCHD intends to use the CAHPS Clinician and Groups visit survey for both adults and pediatrics. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Relationship to other Projects: This is our only Category 1 or 2 project in Pass 3b. The project will help us achieve our Category 3 project outcomes by expanding access to primary care and thus increasing value, timeliness and satisfaction for our patients.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project will ensure patients have access to primary care when they need it. Having access to primary care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to primary Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED.	**5**
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	**3**
Project Scope/Size	While there is opportunity to increase the total number of visits, the population of Hansford County is fairly small thus reducing the potential for significant savings as a result of this project.	**3**
Project Investment	The investment required for this project is high. The cost of adding exam space and recruiting additional staff and providers if very significant. It will take several years to achieve all the goals outlined in this project.	**5**

094117105.1.3 – "PASS 3b"	1.1.2	1.1.2.a-c	Expand Primary Care Capacity, Expand Existing primary care capacity
Hansford County Hospital District dba Hansford County Hospital			094117105
Related CAT 3 Outcome Measure:	094117105.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-1.1 Establish additional/expand existing/relocate primary care clinics **Metric 1: P-1.1** Number of additional clinics or expanded hours or space **Baseline/Goal:** Baseline of 13 exam rooms. Goal is to increase to 20 exam rooms **Data Source:** Documentation of detailed expansion plans **Estimated Milestone 1 Incentive Payment:** *$105,042* **Milestone 2: P-4** Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric1: P-4.1** Increased number of hours at primary care clinic over baseline **Baseline/Goal:**40hr/week/52	**Milestone 3**:I-15. Milestone: Increase access to primary care capacity. **Metric 1: I-15.2.** Increased number of primary care visits. **Baseline/Goal**: 4257/4470 **Data Source**: Registry, EHR, claims or other Performing Provider source **Estimated Milestone 3 Incentive Payment:** $233,112	**Milestone 4: I-11** Patient Satisfaction with primary care services **Metric 1: I-11.2** Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey **Goal:**70% **Data Source:** Performing provider documentation of survey distribution, EHR **Estimated Milestone 4 Incentive Payment:** $112,065 **Milestone 5**:I-15. Milestone: Increase access to primary care capacity. **Metric 1: I-15.2.** Increased number of primary care visits. **Baseline/Goal**: 4470/4695	**Milestone 6: I-11** Patient Satisfaction with primary care services **Metric 1: I-11.2** Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey **Goal:**90% **Data Source:** Performing provider documentation of survey distribution, EHR **Estimated Milestone 6 Incentive Payment:** *$92,311* **Milestone 7**:I-15. Milestone: Increase access to primary care capacity. **Metric 1: I-15.2.** Increased number of primary care visits. **Baseline/Goal**: 4695/4930 **Data Source**: Registry, EHR, claims or other Performing Provider source

hours/week **Data Source:** Clinic Documentation **Estimated Milestone 2 Incentive Payment: $105,041**		**Data Source**: Registry, EHR, claims or other Performing Provider source **Estimated Milestone 5 Incentive Payment:** $112,065	**Estimated Milestone 7 Incentive Payment:** $92,311
DY 2 Estimated Milestone Bundle Amount: *$210,082*	**DY 3 Estimated Milestone Bundle Amount**: $233,112	**DY4 Estimated Milestone Bundle Amount::** $224,130	***DY5 Estimated Milestone Bundle Amount:*** *$184,622*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$851,947*			

Project Option: **1.12.2** Expand the number of community based settings where behavioral health services may be delivered in underserved areas
Performing Provider: Helen Farabee Center/127373205
Unique Project ID: 127373205.1.1

Summary Information (RHP12): CAT 1 1.1 Substance Abuse

- **Provider:** The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider with 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665.

- **Intervention(s):** This project involves hiring a licensed substance abuse counselor who will provide substance abuse services in the Childress, Cottle, King, and Dickens county region.

- **Need for the project:** Currently, Substance Abuse Services are provided in only one county within Helen Farabee Center's catchment area. As a result, substance abuse services are not available for many communities we serve. This project addresses that challenge by expanding services to a community that has previously lacked services.

- **Medicaid and Uninsured Target population:** The Center serves primarily indigent clients and roughly 30% of them have Medicaid.

- **Category 1 or 2 expected patient benefits:** The project seeks to provide substance abuse services to 35 consumers by 9/30/14, increasing services by 10% (39) and 15% (40) over baseline for Demonstration Years 4 and 5, respectively.

- **Category 3 outcomes:** IT-10.1. Our goal is improve quality of life scores for 5% of substance abuse service recipients, increasing to 10% in Demonstration Years 4 and 5 respectively.

Project Option: **1.12.2** Expand the number of community based settings where behavioral health services may be delivered in underserved areas
Performing Provider: Helen Farabee Center/127373205
Unique Project ID: 127373205.1.1

Project Description:
This project involves hiring a licensed substance abuse counselor who will provide substance abuse services in the Childress, Cottle, King, and Dickens county region. The target population for this project includes Adults/Children with a single substance-abuse or dependence diagnoses who do not meet Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. As referrals come in, individuals' treatment needs are assessed by the counselor; treatments are planned and conducted on an outpatient basis at center facilities in the region. Continuous assessments are conducted that inform treatment or if discharge/referral services are indicated. Services are terminated when the needs have been met. The project fits within the Project Area by enhancing the availability of substance abuse services in a location not currently providing them. The project fits the intervention through expanding the number of settings where substance abuse services are provided. The goal is to establish a substance abuse division in key regional areas by hiring staff members and then providing substance abuse services in those counties. Currently, Substance Abuse Services are provided in only one county within Helen Farabee Center's catchment area. As a result, substance abuse services are not available for many communities we serve. This project addresses that challenge by expanding services to a community that has previously lacked services. The expected outcome for the provider is to have established a substance abuse division in additional counties, provide needed services in that community, and to see improved quality of life as measured through standard assessments. Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides access to qualified Substance Abuse counselors as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time in order to begin treatments quickly if indicated (Right Time). This project improves patient experience by providing timely access to care. It improves health by creating a system to begin treatment sooner. It is designed to reduce costs by using alternative and efficient routes of access to substance abuse professionals and by providing care designed to reduce hospitalization and emergency department usage.

Starting Point/Baseline:
Substance Abuse services are being provided only in Wichita County, therefore the baseline for these services in Childress, Cottle, King, and Dickens counties is zero at this time. The expected outcome at the end of the waiver is to have a staffed Substance Abuse division at additional key locations, providing Substance Abuse services on a routine basis.

Rationale:
During the month of May 2012, the Helen Farabee Center solicited feedback via a survey from local stakeholders to inform planning for expansion and improvement of behavioral health services. Access to Mental/ behavioral health care was identified as difficult by 41.2% of the respondents and Substance Abuse services were ranked as the most important service NOT currently provided in all service areas. Access to mental health appointments occurs on a walk-in basis, however if patients require substance abuse services we cannot provide them outside Wichita County at this time. Enhancing service availability for substance abuse services will help meet this need. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[5]. Many patients could be diverted from emergency departments if an immediate Substance Abuse screenings/ interventions were available. Enhancing substance abuse service availability for additional counties requires an expansion of those services into that underserved area. The milestones and metrics were chosen based on the elements required to be in place in order to provide substance abuse services at a new location where none had been provided before. Substance abuse divisions require state licenses, equipment, administrative protocols/guidelines, hiring and training staff, evaluation and improvement activity and tracking utilization. A customizable improvement milestone was selected based on existing milestone I-11.1. This milestone (I-X.1) was customized by removing the "mobile clinic" aspect since this project involves creating a new substance abuse division at an existing facility in Wise County. The customized milestone still measures increased utilization of behavioral health services using roughly the same data source (without referencing expanded transportation programs). The unique community needs addressed are CN.2 and CN8. The project enhances care delivery by providing the Substance Abuse intervention dimension which is currently lacking. It provides Center psychiatrists with immediate referral and coordination options if clinically indicated. It allows the local Mental Health Authority to provide complete behavioral healthcare which includes Substance Abuse services.

Related Category 3 Outcome Measure(s):
IT-10.1 Quality of Life. This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A

[5] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[6]. Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate Substance Abuse screening/ intervention was available. The outcome also reflects any impact substance abuse services will have in ensuring patients remain in the community and abstinent from drugs/alcohol. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients Childress, Cottle, King, and Dickens counties. The milestone increases to 10% for year 5.

Relationship to other Projects:
This Substance Abuse expansion project is related to project "127373205.1. 2 Improve access to specialty care" in that it is providing access to a service that would otherwise require a long wait or not be available in the region.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative:
The target population for this project includes Adults/Children with a single substance-abuse or dependence diagnosis who do not meet Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. Part of this eligibility includes geographic location limited to Childress, Cottle, King, and Dickens counties with the Helen Farabee Center catchment area. We do not believe the project duplicates another provider's intervention for the same target population in these counties. Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:
This project serves the population located in Childress, Cottle, King and Dickens counties. Based on substance abuse arrest records by county we estimate providing substance abuse services to 35 consumers by 9/30/14, increasing services by 10% (39) and 15% (40) over baseline for Demonstration Years 4 and 5, respectively. The benefit to the community is in the form of outpatient access to local substance abuse services which avoids costs associated with emergency department usage or hospitalization. Local funding is in the form of IGT from Helen Farabee Center.

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[6] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Substance abuse imposes a heavy burden on emergency room and primary care settings. When individuals are screened for substance abuse and receive appropriate treatment, the related utilization and abuse of health care settings will go down 50% with a savings of $3.81 to $4.30 for every dollar spent on treatment services. We used the average of $4.05 saved for every dollar spent on treatment services. The savings of $4.05 was determined by the Texas Drug Demand Reduction Advisory Committee Report to state leadership[7]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[7] Texas Drug Demand Reduction Advisory Committee: Report to State Leadership, January 2009 (http://www.dshs.state.tx.us/sa/ddrac/)

127373205.1.1	1.12.2	1.12.2	EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS.	
The Helen Farabee Center				127373205
Related Category 3 Outcome Measure(s):	127373205.3.1	IT-10.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-2. Milestone: Identify licenses, equipment requirements and other components needed to implement and operate options selected Metric 1; P-2.1. Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components Research existing regulations pertaining to the licensure requirements of psychiatric clinics in general to determine what requirements must be met. When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate. Baseline/Goal: Develop plan and secure licenses in preparation for delivery of Substance Abuse services. Data Source: Project Plan	**Process Milestone 3**: P-6. Milestone: Establish behavioral health services in new community-based settings in underserved areas Metric 3: P-6.1. Metric: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: Provide Substance Abuse services to 35 consumers by 09-30-14. Data Source: Number of patients served at these new community-based sites Milestone 3 Estimated Incentive Payment: $54,020 **Milestone 4**: P-7. Milestone: Evaluate and continuously improve services Metric 4: P-7.1. Metric: Project planning and implementation documentation		**Improvement Milestone 1**: I-11. Milestone: Increased utilization of community behavioral healthcare Metric 1: I-11.1. Metric: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from new substance abuse division after access expansion (DY3 target of 35) b. Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision of Substance Abuse services by 10% over baseline (39) by 09-30-15 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 1 Estimated Incentive Payment: $115,530	**Improvement Milestone 2**: I-11. Milestone: Increased utilization of community behavioral healthcare Metric 2: I-11.1. Metric: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from new substance abuse division after access expansion (DY3 target of 35) b. Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision of Substance Abuse services by 15% over baseline (40) by 09-30-16 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 2 Estimated Incentive Payment: $111,578

127373205.1.1	1.12.2	1.12.2	EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS.	
The Helen Farabee Center				127373205
Related Category 3 Outcome Measure(s):	127373205.3.1	IT-10.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment *(maximum amount):* $49,734 **Process Milestone 2:** P-4. Milestone: Hire and train staff to operate and manage projects selected <u>Metric 2:</u> P-4.1. Metric: Number of staff secured and trained Baseline/Goal: Hire and train one Licensed Chemical Dependency Counselor to provide Substance Abuse services. Data Source: Project records; Training curricula as develop in P-2 Milestone 2 Estimated Incentive: $49,734	demonstrates plan, do, study act quality improvement cycles Baseline/Goal: Complete first project report which includes a review of service encounters, analysis and recommended changes. Data Source: Project reports Milestone 4 Estimated Incentive Payment: $54,021			
Year 2 Estimated Milestone Bundle Amount: $99,468	Year 3 Estimated Milestone Bundle Amount: $108,041		Year 4 Estimated Milestone Bundle Amount: $115,530	Year 5 Estimated Milestone Bundle Amount: $111,578
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $434,617				

Project Option: 1.9.2 Improve access to specialty care
Performing Provider: Helen Farabee Center/127373205
Unique Project ID: 127373205.1.2
Project Components: 1.9.2.a-d

Summary Information (RHP 12): CAT 1 1.2 Open Access

- **Provider:** The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider with 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665.

- **Intervention(s):** This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services. The expanded hours will provide for open-access (on-demand) routine psychiatric evaluations for individuals determined eligible to receive services under the Texas Recovery and Resiliency model.

- **Need for the project**: Currently, the average wait time for an initial psychiatric evaluation is ten weeks making access to much needed psychiatric medical care delayed at the Helen Farabee Center. The project addresses this barrier by creating on open-access (on-demand) model for psychiatric evaluation via telemedicine occurring within 1 business day.

- **Medicaid and Uninsured Target population:** The Center serves primarily indigent clients and roughly 30% of them have Medicaid.

- **Category 1 or 2 expected patient benefits:** The project seeks to provide on-demand psychiatric evaluations to roughly 9 patients in DY2 increasing to 12 and 13 over Demonstration Years 4 and 5, respectively. Another goal is to increase the number of unique patients by 2.5% over baseline increasing to 5% over Demonstration Years 4 and 5, respectively.

- **Category 3 outcomes**: IT-10.1. Our goal is improve quality of life scores for 5% of on-demand evaluation recipients, increasing to 10% in Demonstration Years 4 and 5 respectively.

Project Option: 1.9.2 Improve access to specialty care
Performing Provider: Helen Farabee Center/127373205
Unique Project ID: 127373205.1.2
Project Components: 1.9.2.a-d

Project Description:
This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services. The expanded hours will provide for open-access (on-demand) routine psychiatric evaluations for individuals determined eligible to receive services under the Texas Recovery and Resiliency model. The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders).The project fits within the Project Area since psychiatry is considered specialty care and is being expanded. The project fits within the Intervention in that the expansion of psychiatric availability improves access to these services by eligible individuals. The project goals include collecting baseline data for wait times, completing and submitting a plan for electronic referrals, training medical staff, implementing referral technology to improve provider communications, and incrementally increasing the volume of specialty care visits via the open-access model. Currently, the average wait time for an initial psychiatric evaluation is ten weeks making access to much needed psychiatric medical care delayed at the Helen Farabee Center. The project addresses this barrier by creating on open-access (on-demand) model for psychiatric evaluation via telemedicine. The team implementing this project consists of initial intake clinicians who make the initial referrals for psychiatric evaluations, support staff who coordinate the video session, and contracted psychiatrists and other medical support personnel who conduct the evaluations.
There is currently no mechanism for on-demand (walk-in) psychiatric evaluations for routine outpatient behavioral health services. The expected outcome during the waiver period is to increase the number of psychiatric evaluations provided within one business day by creating an on-demand model. This is designed to have the anticipated effect of improving quality of life through removing a barrier to outpatient behavioral health services. Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides an on-demand psychiatric evaluation for routine mental health inquiries as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time which is within 1 business day of the inquiry in order to begin treatments quickly if indicated (Right Time). This project improves patient experience by providing timely access to care. It improves health by creating a system to begin *treatment sooner. It is designed to reduce costs by using alternative and efficient routes of access to prescribing professionals and by providing care designed to reduce hospitalization and emergency department usage.*

Starting Point/Baseline:
Although the Center provides scheduled psychiatric evaluations for these counties per year, there are currently no on-demand psychiatric evaluations for routine behavioral health services.

Rationale:
Expediting services can decrease symptoms and increase functioning in individuals ensuring timely access to initial evaluations and freeing up other prescribers to provide quicker follow up encounters. Neufeld, et al. (2012)[8] used the mean time between appointments as potential indicators for measuring quality of life. An on-demand (walk-in) model of care would expedite services, potentially reduce psychiatric admissions[9], and potentially reduce emergency department usage by individuals in Childress, Cottle, King, and Dickens counties. The project component (increasing service availability with extended hours) was chosen in order to provide a cost-effective[10] and concrete way to improve access to psychiatric services. Core component (b) "Increase the number of specialty clinic locations" was not address since our region has an adequate number of physical access points. Component (c) "Implement transparent, standardized referrals across the system" is chosen in order to ensure efficient access to the new on-demand evaluation services. Component (d) "Conduct quality improvement for project using methods such as rapid cycle improvement" was selected in order to maintain quality of access while also tracking and reporting on utilization at frequent intervals. Access to behavioral health care was identified as difficult by 41.2% of community stakeholder respondents and barriers to access in terms of long wait times were identified as most important by 40.9%. Baseline data is being collected in order to know the extent to which access to psychiatric services has been improved through then open access model. Implementation plans for e-referrals ensure efficiency in the referral process. Training specialty care providers is required with a new access model of care. Developing and implementing technical referral capabilities will enable improved and streamlined provider communications. The improvement milestone of increasing clinic volume and improving patient access will help remove access barriers perceived by the community. The project significantly enhances the existing delivery of psychiatric evaluations by eliminating the potentially 10 week wait for medical interventions for routine behavioral health conditions. The open-access model is designed to provide psychiatric

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[8] Neufeld, J. (2012). Walk-In Telemedicine Clinics Improve Access and Efficiency: A Program Evaluation From the Perspective of a Rural Community Mental Health Center. *Rural Mental Health, Fall/Winter 2012,* 33-37. Retrieved October 12, 2012, from http://newprairiepress.org/journals.html
[9] The American Psychiatric Association's 2012 Annual Meeting. Abstract SCR10-3, presented May 6, 2012.
[10] Neufeld, J. (2012). Walk-In Telemedicine Clinics Improve Access and Efficiency: A Program Evaluation From the Perspective of a Rural Community Mental Health Center. *Rural Mental Health, Fall/Winter 2012,* 33-37. Retrieved October 12, 2012, from http://newprairiepress.org/journals.html

evaluations the same day as or next business day following the determination that they are eligible for services. The project meets identified community need CN.2.

Related Category 3 Outcome Measure(s):
IT-10.1 Quality of Life. This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[11]. Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate psychiatric evaluation were available. The outcome also reflects any impact psychiatric evaluation services will have in ensuring patients remain in the community. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the ANSA, for 5% of patients in Childress, Cottle, King, and Dickens County. The milestone increases to 10% for year 5.

Relationship to other Projects:
The Project relates to "127373205.1.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas" in that it also provides a behavioral health service in an area that currently has very limited access to the service.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative:
The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). Part of this eligibility includes geographic location limited to Childress, Cottle, King, and Dickens counties within the Helen Farabee Center catchment area. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. We do not believe the project duplicates another provider's intervention for the same target population. Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully

[11] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

This project serves the population located in Childress, Cottle, King and Dickens counties. We estimate providing intakes to 9 patients in DY2 based on past demand and current usage patterns. The impact increases to 12 in DY4 and 13 in DY5. The benefit to the community is in the form of on-demand access to services which avoids costs associated with emergency department usage or hospitalization. Local funding is in the form of IGT from Helen Farabee Center. This project is not receiving other federal funding.

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years. Based on the literature, an estimated Quality of Life Year gained by this intervention is 0.0245 years. The result is a $1,225 quality of life improvement per patient impacted. The valuation is aligned with the Medicaid Waiver goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research). Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The number of life-years added is based on a review of the scientific literature. A search of the scientific literature identified the following two studies. The first study looked at telemedicine and mental health and was conducted by Pyne (2010) [12] which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010) [13] examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

[12] Pyne, J. M., Fortney, J. C., Tripathi, S. P., Maciejewski, M. L., Edlund, M. J., & Williams, D. K. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Arch Gen Psychiatry, 67*(8), 812-821.

[13] Hollinghurst, S., Peters, T. J., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomized controlled trial. *Br J Psychiatry, 197*(4), 297-304.

1273733205.1.2	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE.
The Helen Farabee Center			*127373205*
Related Category 3 Outcome Measure(s):	1273733205.3.2	IT-10.1	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: P-3. Milestone: Collect baseline data for wait times, backlog, and/or return appointments in specialties **Metric 1:** P-3.1. Metric: Establish baseline for performance indicators **Baseline/Goal:** To determine the average wait time for an initial psychiatric evaluation. (estimated evaluation demand is 9 in DY2). **Data Source:** EHR, Internal Database **Milestone 1 Estimated Incentive Payment:** $3,418 **Process Milestone 2:** P-7. Milestone: Complete a planning process/submit a plan to implement electronic referral technology **Metric P-7.2** Development of an implementation plan for e-referral **Baseline/Goal:** Develop a plan that will guide the implementation and technical needs of e-referrals for the on-demand model	**Process Milestone 4: P-8.** Develop the technical capabilities to facilitate electronic referral **Metric 1: P-8.1**. Metric: Demonstrate technical mechanisms to be used to operate referral system are in place **Baseline/Goal:** Develop a Referral Management system that will enable providers to efficiently refer consumers for psychiatric evaluations in the on-demand model **Data Source:** Referral Management system **Milestone 4 Estimated Incentive Payment:** $4,149 **Process Milestone 5:** P-9 Implement referral technology and processes that enable improved and more streamlined provider communications Metric 1: Documentation of referrals technology **Baseline/Goal:** With improved technology and e-referral, to establish	**Improvement Milestone 1:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). a. Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by 5% over baseline by 09-30-15. (Estimated at 12 patients) Data Source: Registry, EHR, claims or other Performing Provider source Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline	**Improvement Milestone 2:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 2: I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). a. Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by 10% over baseline by 09-30-16. (Estimated at 13 patients) Data Source: Registry, EHR, claims or other Performing Provider source Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels.

1273733205.1.2	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE.
The Helen Farabee Center			*127373205*
Related Category 3 Outcome Measure(s):	1273733205.3.2	IT-10.1	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: Referral plan, which describes the technical mechanisms needed to operate e-referral system. **Milestone 2 Estimated Incentive Payment**: $3,418 **Process Milestone 3:** P-2. Milestone: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties **Metric: P-2.1** Training of staff and providers on referral guidelines, process and technology **Baseline/Goal:** To train providers on e-referrals so that the on-demand model of care is a more efficient and effective service for the consumer. **Data Source:** Log of specialty care personnel trained and Curriculum for training. **Milestone 3 Estimated Incentive Payment:** $3,418	more efficient and fluid communication among providers for the on-demand model of care Data Source: Referral system Milestone 5 Estimated Incentive Payment: $4,149 **Process Milestone 6:** P-11. Milestone: Launch/expand a specialty care clinic (e.g., pain management clinic) Metric 6: P-11.1. Metric: Establish/expand specialty care clinics a. Number of patients served by specialty care clinic Baseline/Goal: To initiate the on-demand model of care for psychiatric evaluations. Data Source: Documentation of new/expanded specialty care clinic Milestone 6 Estimated Incentive Payment $4,150	for DY2). Total number of unique patients encountered in the clinic for reporting period. Goal: Increase unique number of patients by 2.5% over baseline. Data Source: patient registry Milestone 1 Estimated Incentive Payment: $13,365	Demonstrate improvement over prior reporting period (baseline for DY2). Total number of unique patients encountered in the clinic for reporting period. Goal: Increase unique number of patients by 5% over baseline. Data Source: patient registry Milestone 2 Estimated Incentive Payment: $12,958
Year 2 Estimated Milestone Bundle Amount: $10,254	Year 3 Estimated Milestone Bundle Amount: $12,448	Year 4 Estimated Milestone Bundle Amount: $13,365	Year 5 Estimated Milestone Bundle Amount: $12,958
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $49,025			

Project Title: 1.1.2 Expand Primary Care Capacity, Expand Existing Primary Care Capacity
Performing Provider: Hereford Regional Medical Center/133544006
RHP Unique Identification Number: 133544006.1.1

- **Provider:** Hereford Regional Medical Center is a 42 bed hospital located in Hereford, TX serving a 1,498 square miles and a population of approximately 19,500.
- **Intervention:** Deaf Smith County is nationally recognized as a Health Provider Shortage Area (HPSA) so the recruitment and retention of new and existing primary care providers is an imperative for the county and the region. This project will expand primary care capacity to provide to our population additional access to providers.
- **Need for the Project:** The need for this project is the ratio of primary care providers to population currently sitting at 1/1761. With the completion of this project we will be adding three additional providers and thus decreasing the ratio of primary care providers to population to 1/1384. This project will increase the number of primary care hours being provided to our population thus making primary care more easily available to our patients and our ability to take care of additional patients will increase at least 33%.
- **Target population:** The target population is our patients that need additional hours and access to primary care. Approximately 38% of our gross revenues are either Medicaid, self-pay or indigent, so we expect they will benefit from over a third of the additional hours. The increase of access to primary care by the increase in hours will make available an additional 2,500 visits per year per provider. For the target population Medicaid, self-pay, and indigent that will increase available visits will be approximately 950 per provider per year. Over the total waiver period the increase in available visits for the target population will be approximately 2,850 additional visits per year.
- **Category 1 expected patient benefits:** This project seeks to provide an additional 5,475 hours of additional access to primary care for our patients in DY4 and DY5. That will be an increase of 37.5% over our current primary care availability.
- **Category 3 outcomes:** IT-6.1 Our goal is to improve over baseline patient satisfaction scores for our patients getting timely care, appointments and information by 2% in DY4 and 3% in DY5 thus creating more value for our patients.

Project Title: 1.1.2 Expand Primary Care Capacity, Expand Existing Primary Care Capacity

Performing Provider: Hereford Regional Medical Center/133544006

RHP Unique Identification Number: 133544006.1.1

Project Components: 1.1.2.a-c

Project Description: The goal of this project is to expand the capacity of primary care to better accommodate the needs of the community and the regional patient population, as identified in the RHP 12 needs assessment. This project has two goals. First it will improve patient access to primary care by systemically changing clinic space, hours and staffing. The addition of new primary care practitioners and physicians to the current number of primary care physicians and practitioners, will give patients more immediate access to primary care. Second this project will increase interrelationships between hospital and clinic physicians and practitioners.

The main challenges facing the successful completion of this project are related to the shortfall of current primary care physicians practicing as well as the number of new primary care physicians graduating from residency programs. With aim of this project is to not only add three additional primary care providers, but also retaining as many of the current primary care providers working in Deaf Smith County over the course of the 5 year waiver period. By successfully completing this project we will have expanded primary care capacity by over 37%.

Starting Point/Baseline: Currently, the clinic has 5 primary care physicians, one of which is 73 years old, as well as 3 midlevel primary care practitioners. They combine to provide roughly 14,600 hours of primary patient care per year or 64 hours per day.

Rationale: Deaf Smith County is nationally recognized as a Health Provider Shortage Area (HPSA) so the recruitment and retention of new and existing primary care providers is an imperative for the county and the region. The greatest healthcare challenge faced by Deaf Smith County and the region is the shortage of primary care physicians nationwide with the gap of what is needed and supplied widening. According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451,577 in 2040. More primary care physicians are a badly needed asset for the present and the future of healthcare in RHP-12 Rural Region communities. The most glaring evidence of the challenges facing rural communities in Region 12 is the shortage of primary care practitioners currently providing services to our population. In 2007, the state ratio of total persons to each direct patient care and primary care physician was 386. For that same year, the regional ratio was 991.1 residents per direct patient care and primary care physician. As of 2010, the ratio for Deaf Smith County residents was 1 primary care physician or practitioner for every 1761 persons. Deaf Smith County's acute shortage of primary care physicians and practitioners is almost double that of her region and quadruple that of the state. For the everyday county resident that means a wait to be examined and treated for both minor and more serious healthcare issues.

A second advantage for many Deaf Smith County residents will be realized by increasing our primary care practitioners and that is improved access to health and wellness care for lower socioeconomic patients. According to the Needs Assessment for Region 12, the poverty level is higher (16.6% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Deaf Smith County residents puts them at a far greater risk for health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development. An increase in the number of primary care practitioners as well as clinic service hours will directly impact the accessibility of lower socioeconomic patients to healthcare.

Also, by enhancing available primary care capacity though expanding clinic space, hours and staffing, patients and families will have more opportunity to align themselves with our primary care providers resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services.

This project will retain the current number of primary care practitioners and providers as well as adding three additional primary care providers and practitioners. With the retention and the addition of new providers to the clinic the number of hours for direct patient care will be increase eight hours per day by the end of DY 3 of the five year waiver period. This increase will translate to an additional 1,840 hours of primary patient care by the end of the five year demonstration project. In years 4 and 5 of the project additional providers will be added at a rate of one per year. At the end of the demonstration project the number of primary care hours provided will have been increased 24 hours per day or 5,520 hours per year. The ratio of total persons to each direct patient care and primary care physician and practitioner will be lowered to 1,384.

The square footage needed for the additional primary care providers has already been built, but the furniture, computers telephones, exam tables and other equipment will need to be purchased to completely set up the clinic space for the new providers. Also, staff will need to be hired and trained to more fully support the expanded primary care capacity.

Target Population & Zip Codes:
Residents of Deaf Smith County – 79045, 79025, 79035, 79092, 79098

Community Need Identification Number:

Expand Primary Care Capacity – 1 - CN.1, CN.3
CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
CN.3 - Poor insurance support or uninsured.

Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction - IT 6.1 (1) are getting timely care, appointments and information; (Standalone Measure).

The Category 3 outcome is directly related to this Category 1 project in the respect that the outcome for this project will not only allow more individual access to primary care but will also accentuate the value of that care. The Category 3 project will develop and that the value of the Category 1 project through patient satisfaction scores thus ensuring our patients benefit and value for their time.

Also, with the increase of clinic time, space and staff this project will significantly also help increase our possible Category 3 outcomes because of expanded access to primary care physicians and providers.

Relationship to other Projects: This is our only Category 1 or 2 project in Pass 1. The project will help us achieve our Category 3 project outcomes by expanding access to primary care and thus increasing value, timeliness and satisfaction for our patients.

Relationship to Other Performing Providers' Projects in RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	The Waiver goals for this project are to improve existing processes in the primary care clinic as well as integrate the addition primary care physicians and practitioners being hired over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction (Category 3 project) our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient.	**5**
Addresses Community Need(s)	According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. More primary care physicians are a badly needed asset for the present and the future of healthcare in RHP-12 Rural Region communities. The most glaring evidence of the challenges facing rural communities in Region 12 is the shortage of primary care practitioners currently providing services to our population. In 2007, the state ratio of total persons to each direct patient care and primary care physician was 386. Also, according to the Needs Assessment for Region 12, the poverty level is higher (16.6% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Deaf Smith County residents puts them at a far greater risk for health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development.	**5**
Project Scope/Size	This expansion of primary care capacity project will be the biggest demonstration waiver project undertaken by Hereford Regional Medical Center. The focus of healthcare provided by the Hereford Regional Medical Center and the Hereford Health Clinic is primary care. Our mission is to provide the best quality of primary care to the individuals of our communities and county as possible. This project is the only DSRIP project including the Category 3 project relating to patient satisfaction for Pass 1. The project will decrease the ratio of total number of individuals per primary care physician and practitioner from 1,761 to 1,384 with the expansion of primary care capacity with the addition of three primary care physicians and practitioners.	**5**
Project Investment	The first year project investment for a primary care physician is estimated to be $644,700 and the ongoing investment in retaining the physician is $502,000. The first year project investment for a primary care practitioner is estimated to be $404,700 and the ongoing investment in retaining the practitioner is $352,000. With the additional investment of retaining the current number of primary care physicians and practitioners estimated to be $75,000 per year the total investment for years 2 through 5 of the waiver is calculated to be $3,852,100.	**5**

133544006.1.1	1.1.2	1.1.2.a-c	Expand Primary Care Capacity, Expand Existing Primary Care Capacity
Deaf Smith County Hospital District dba Hereford Regional Medical Center			**133544006**
Related Category 3 Outcome Measure(s):	**133544006.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1 [P-5]: Hire additional primary care providers and staff. **Metric 1 [P-5.1]:** Documentation of increased number of providers and staff. **Goal:** Execute one contract for an additional Primary Care Physician or Practitioner **Data Source:** Executed contract for one additional primary care physician or practitioner. **Estimated Milestone 1 Incentive Payment:** $482,675	**Milestone 2 [I-15]:** *Increase access to primary care capacity.* ***Metric 2 [I-15.2]:*** *Increase number of primary care visits.* ***Data Source:*** *EHR face to face encounters.* **Goal:** Increase number of visits 2,500 over baseline of 20,000 visits. **Estimated Milestone 2 Incentive Payment:** $291,741 **Milestone 3 [P-5]:** Hire additional primary care providers and staff. **Metric 3 [P-5.1]:** Documentation of increased number of providers and staff. **Goal:** Execute one additional contract for a Primary Care Physician or Practitioner **Data Source:** Executed contract for one additional primary care physician or practitioner. **Estimated Milestone 3 Incentive Payment:** $291,742	**Milestone 4 [I-15]:** *Increase access to primary care capacity.* ***Metric 4 [I-15.2]:*** *Increase number of primary care visits.* ***Data Source:*** *EHR face to face encounters.* **Goal:** Increase number of visits 2,500 over baseline of 22,500 visits. **Estimated Milestone 4 Incentive Payment:** $282,633 **Milestone 5 [P-5]:** Hire additional primary care providers and staff. **Metric 5 [P-5.1]:** Documentation of increased number of providers and staff. **Goal:** Execute one additional contract for a Primary Care Physician or Practitioner **Data Source:** Executed contract for one additional primary care physician or practitioner. **Estimated Milestone 5 Incentive Payment:** $282,633	**Milestone 6 [I-15]:** *Increase access to primary care capacity.* ***Metric 6 [I-15.2]:*** *Increase number of primary care visits.* ***Data Source:*** *EHR face to face encounters.* **Goal:** Increase number of visits 2,500 over baseline of 25,000 visits. **Estimated Milestone 6 Incentive Payment:** $242,153 **Milestone 7 [P-5]:** Increase the number of primary care clinics for existing providers. **Metric 7 [P-5.1]:** Documentation of increased number of clinic sites. **Goal:** Allocate square footage in another area of the hospital district or execute a contract for a clinic in another building. **Data Source:** Executed contract for additional clinic space or show allocation of new space in existing utilized as new clinic space. **Estimated Milestone 7 Incentive Payment:** $242,154

133544006.1.1	**1.1.2**	**1.1.2.a-c**	**Expand Primary Care Capacity, Expand Existing Primary Care Capacity**	
Deaf Smith County Hospital District dba Hereford Regional Medical Center			**133544006**	
Related Category 3 Outcome Measure(s):	**133544006.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
DY 2 Estimated Milestone Bundle Amount: $482,675	DY 3 Estimated Milestone Bundle Amount: $559,483		DY4 Estimated Milestone Bundle Amount: $565,266	*DY5 Estimated Milestone Bundle Amount: $484,307*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,091,731				

Project Option: 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas

Performing Provider / TPI: Hereford Regional Medical Center/133544006

RHP Unique Identification Number: 133544006.1.2 – **"PASS 2"**

- **Provider:** Hereford Regional Medical Center is a 42 bed hospital located in Hereford, TX serving a 1,498 square miles and a population of approximately 19,500.
- **Intervention:** Deaf Smith County is nationally recognized as a Health Provider Shortage Area (HPSA) so the recruitment and retention of new and existing primary care providers is an imperative for the county and the region. This project will expand primary care capacity to provide to our population additional access to providers.
- **Need for the Project:** The need for this project is the ratio of primary care providers to population currently sitting at 1/1761. With the completion of this project we will be adding three additional providers and thus decreasing the ratio of primary care providers to population to 1/1384. This project will increase the number of primary care hours being provided to our population thus making primary care more easily available to our patients and our ability to take care of additional patients will increase at least 33%.
- **Target population:** The target population is our patients that need additional hours and access to behavioral health services. Approximately 38% of our gross revenues are either Medicaid, self-pay or indigent, so we expect they will benefit from over a third of the additional hours. The expanded number of community based setting where behavioral health services are being delivered will help increase of access to primary care by the increase in hours will make available an additional 2,500 visits per year per provider. For the target population Medicaid, self-pay, and indigent that will increase available visits will be approximately 950 per provider per year. Over the total waiver period the increase in available visits for the target population will be approximately 2,850 additional visits per year.
- **Category 1 expected patient benefits:** This project seeks to provide an additional 5,475 hours of additional access to primary care for our patients in DY4 and DY5. That will be an increase of 37.5% over our current primary care availability.
- **Category 3 outcomes:** IT-6.1 Our goal is to improve over baseline patient satisfaction scores for our patients getting timely care, appointments and information by 2% in DY4 and 3% in DY5 thus creating more value for our patients.

Project Option: 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas

Performing Provider / TPI: Hereford Regional Medical Center/133544006

RHP Unique Identification Number: 133544006.1.2 – **"PASS 2"**

Project Description: The goal of this project is to expand the capacity of behavioral health services to better accommodate the needs of the community and the regional patient population, as identified in the RHP 12 needs assessment. This project has two goals. First it will improve patient access to behavioral health care systemically changing clinic space, hours and staffing. The addition of new behavioral health care practitioners to the clinic setting, will give patients more immediate access to behavioral health care. Second this project will increase interrelationships between hospital and clinic primary care physicians and practitioners with the new behavioral health provider for a more total patient care experience. Third this project will identify regional need by addressing the lack of behavioral health providers in the region. Community Identification number CN2 shows a regional lack of behavioral health services.

Starting Point/Baseline: Currently, the clinic has zero behavioral health practitioners dedicated to the mental health of patients.

Rationale: Deaf Smith County is nationally recognized as a Health Provider Shortage Area (HPSA) for Mental Health so the recruitment of new mental health providers is an imperative for the county and the region. According to the Health Professional Shortage Area website for the U.S. Department of Health and Human Services, Deaf Smith County, Texas is short one full time mental health provider and since currently Deaf Smith County has zero dedicated practicing mental health providers working in Deaf Smith County the addition of one provider will fill the basic mental health need for the county.

As of 2010, the ratio for Deaf Smith County residents was 1 primary care physician and practitioner for every 1761 persons. Deaf Smith County's acute shortage of primary care physicians and practitioners is almost double that of the region and quadruple that of the state. More importantly the only mental health services currently provided are performed by the patient's primary care physician or provider. The challenges facing rural communities in Region 12 with the shortage of primary care practitioners currently providing services to our population and the limited time those primary care providers can allocate to the delivery of mental health care, the addition of a dedicated mental health provider will help relieve some of the patient stress associated with being treated by a provider that doesn't provide mental health full time and as well as "opening up" time for additional patients to be seen for primary health care needs.

According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451,577 in 2040. The complete lack of a trained mental health provider will only be exacerbated over the coming years with additional increase in projected population.

A second advantage for many Deaf Smith County residents will be realized by increasing our mental health care practitioners and improving access to mental health for lower socioeconomic patients. According to the Needs Assessment for Region 12, the poverty level is higher (16.6% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Deaf Smith County residents puts them at a far greater risk for mental health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development. An addition of a mental health practitioner will directly impact the accessibility of lower socioeconomic patients to mental health.

This project will add mental health services in Deaf Smith County by obtaining the services of at least one mental health practitioner providing services in the clinic. The baseline for the need of a behavioral health provider will be established in DY3 after the provider has been acquired in DY2. Because of barriers inherently built into the process of individuals seeking behavioral health services, a baseline will be determined to track the number of cancelled or no-show appointments in DY3. With adjustments to schedule availability times and other barriers directly addressed, we seek to decrease the percentage of cancelled or no-show appointments by 2% in DY4 and 5% in DY5 from baseline thus increasing the value of the new and enhanced behavioral health services being provided in this project.

The goal of this project is to not only expand the number of community based settings where behavioral health services may be delivered in Deaf Smith County but also to determine what the baseline for cancelled and “no-show” appointments. By the end of year five we approximate a decrease in cancelled and “no-show” appointments of 5%. With the introduction of the behavioral health services and providers to address our HPSA designated shortage for mental health our goal is to address an outstanding and recognized issue within our community and patient base.

Target Population & Zip Codes:
Residents of Deaf Smith County – 79045, 79025, 79035, 79092, 79098

Community Need Identification Number:

Expand service availability(i.e., hours) to appropriate levels of behavioral health care – 1 - CN.1, CN.2, CN.5

CN.1	Severe primary care provider shortage, wait time, expense, lack of insurance, access to care	BRFSS data, Focus groups, survey, DSHS
CN.2	Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.	BRFSS data, survey, focus groups. DSHS data
CN.5	Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung lung disease. Travel to Urban areas for care is difficult.	BRFSS Data

Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction
The Category 3 outcome is directly related to this Category 1 project in the respect that the outcome for this project will not only allow more individual access to mental health care but will also accentuate the value of that care by addressing complete patient wellness.

Relationship to other Projects: This project will accentuate our Pass 1 Category 1 project of expanding primary care access (1.1.2 Expand existing primary care capacity) by not only providing mental health care by a trained mental health provider, but will also freeing up our existing providers time they are currently spending on mental health issues. This project will enable us to utilize that time to take care of other primary care patients.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	The Waiver goals for this project are to improve access to mental health care by expanding the number of community based setting where behavior health services may be delivered in underserved areas. This project will also achieve waiver goals by accentuating our other Category 1 project freeing up time of our primary care providers time to see more patients with primary care issues. With this addition and successful identification of patient satisfaction (Category 3 project) our organization will be able to more directly and accurately address patients concerns, both mental and physical, in relation to the satisfaction of their care thus increasing the value for the patient.	**4**
Addresses Community Need(s)	According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. The complete lack of a trained mental health provider will only be exacerbated over the coming years with additional increase in projected population. Deaf Smith County's acute shortage of primary care physicians and practitioners is almost double that of the region and quadruple that of the state. More importantly the only mental health services currently provided are performed by the patient's primary care physician or provider. The challenges facing rural communities in Region 12 with the shortage of primary care practitioners currently providing services to our population and the limited time those primary care providers can allocate to the delivery of mental health care, the addition of a dedicated mental health provider will help relieve some of the patient stress associated with being treated by a provider that doesn't provide mental health full time and as well as "opening up" time for additional patients to be seen for primary health care needs. Also, according to the Needs Assessment for Region 12, the poverty level is higher (16.6% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Deaf Smith County residents puts them at a far greater risk for mental health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development. An addition of a mental health practitioner will directly impact the accessibility of lower socioeconomic patients to mental health.	**4**
Project Scope/Size	This expansion of the number of locations where behavioral health is being provided will take place in the Hereford Health Clinic. A search will be initiated and space (offices, phones, scheduler, staff, supplies, etc.) will be setup to provide the appropriate services outlined in the project. Our mission is to provide the best quality of health care to the individuals of our communities and county as possible. This project is the only DSRIP project including the Category 3 project relating to patient satisfaction for Pass 2.	**2**

Criteria	Narrative	Score (1-5)
Project Investment	The first year project investment for expanding the number of community based settings where behavioral health services are provided will encompass a search initiation and studies of what is required for the implementation of providing behavioral health care. It is estimated to cost for the first year to be $80,000 and the ongoing investment in retaining the physician is $95,000.	**2**

133544006.1.2	1.12.2	N/A	Expand the number of community based settings where behavioral health services may be delivered in underserved areas
Hereford Regional Medical Center			**133544006**
Related Category 3 Outcome Measure(s):	**133544006.3.2**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1[P-6]: Establish behavioral health services in new community-based settings in underserved areas. **Metric 1 [P-6.1]:** Number of new community-based settings where behavioral health services are delivered. **Goal:** Execute contract/agreement with new behavioral health provider and develop a baseline for canceled or "no-show appointments. **Data Source:** Executed agreement. **Estimated Milestone 1 Incentive Payment:** $75,920	**Milestone 2 [I-13]:** Adherence to scheduled appointments. **Metric 2 [I-13.1]:** X% decrease in number of canceled or "no-show" appointments. **Baseline:** 1% decrease in the number of canceled or "no-show" appointments from baseline established in DY2. **Data Source:** Clinical records from expanded access sites. **Estimated Milestone 2 Incentive Payment:$**84,243	**Milestone 3 [I-13]:** Adherence to scheduled appointments. **Metric 3: [I-13.1]:** X% decrease in the number of canceled or "no-show" appointments. **Goal:** 2% decrease in the number of canceled or "no-show" appointments from baseline established in DY2. **Data Source:** Clinical records from expanded access sites. **Estimated Milestone 3 Incentive Payment:$**80,997	**Milestone 4 [I-13]:** Adherence to scheduled appointments. **Metric 1[I-13.1]:** X% decrease in the number of canceled or "no-show" appointments **Goal:** 5% decrease in the number of canceled or "no-show" appointments from baseline established in DY2. **Data Source:** Clinical records from expanded access sites. **Estimated Milestone 4 Incentive Payment:** $66,720
DY 2 Estimated Milestone Bundle Amount: *$75,920*	**DY 3 Estimated Milestone Bundle Amount:** $84,243	**DY4 Estimated Milestone Bundle Amount:** $80,997	**DY5 Estimated Milestone Bundle Amount:** $66,720
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$307,880*			

Project Option: 1.1.2 Expand Existing Primary Care Clinics, Expand Existing Primary Care Capacity
Performing Provider: Lubbock Heritage Hospital, LLC, d/b/a Grace Medical Center/281514401
RHP Unique Identification Number: 281514401.1.1
Project Components: 1.1.2.a-c

Provider: Grace Medical Center is a 123 bed hospital located in a federally designated primary care Healthcare Provider Shortage Area (HPSA) in Lubbock, Texas. It is the only hospital in Lubbock that is located in a HPSA serving census tracts 13, 14, 22.02, 22.04, 23 and 24. Grace Medical Center is located in census tract 23. Because the hospital is located in an underserved area, numerous patients seek care through the emergency room. In CY2011, Grace Medical Center had 11,784 Emergency Room visits of which 36% were self-pay and 24% were Medicaid patients.

Intervention: Grace Medical Center will, through Grace Clinic of Lubbock, recruit 2 additional primary care providers to serve the community in the underserved location This project will increase the. The providers may be Family Medicine, Internal Medicine or mid-level providers. The project goal is to provide access to primary care in the appropriate setting. The expected outcome is to increase the number of new primary care clinic visits and reduce low level visits to the Emergency Department (Triage levels 4 and 5)). Grace will recruit new providers, open a new walk-in clinic location in the HPSA, establish provider and ER benchmarks, and perform a PSDA of the case management intervention and scheduling system.

Need for the project: The neighborhood in which the hospital is located has very limited accessibility to primary care; thus, many patients use the emergency department inappropriately.

Target population: The target population is the underserved Medicaid and self-pay patients who live in the HPSA zip codes 79412, 79404, and 79423 that present to the Emergency Department for low acuity problems (triage level 4 and 5) because they do not have access to a primary care physician. There are currently approximately 61,400 people living in the target zip codes. Based on Grace's Emergency Department payor mix, Grace projects that 60% or 36,840 individuals are Medicaid or self-pay. Grace cared for 5,893 patients from the targeted zip codes in DY1. Grace Medical Center currently operates one walk-in clinic through Grace Clinic of Lubbock. There are currently 7,070 Medicaid and uninsured patient visits annually at the Grace Medical Center ER. Out of that 7,070 patients, Grace will establish the baseline visits of patients that live in the HPSA as the target population

Category 1 Expected patient benefits: Grace Medical Center expects to build a walk-in clinic, hire and train providers and staff to provide walk-in care to the self-pay and Medicaid patients so that these individuals will reduce their use of the ER for non-emergent care and increase primary care visits by 4,000 over the baseline of 52,161 visits.

Category 3 expected patient benefits: Grace Medical Center expects to reduce low acuity visits (triage level 4 and 5) of the target population by 10% from the baseline established in DY2.

Project Option: 1.1.2 Expand Existing Primary Care Clinics, Expand Existing Primary Care Capacity
Performing Provider: Lubbock Heritage Hospital, LLC, d/b/a Grace Medical Center/281514401
RHP Unique Identification Number: 281514401.1.1.2
Project Components: 1.1.2.a-c

Project Description: RHP12 has identified the need to expand primary care as its most critical community need. Grace Medical Center selected this project based on the high priority placement of this project in RHP12. The target population for this project is the underserved Medicaid and self-pay patients who live in the HPSA census tracts 13, 14, 22.02, 22.04, 23, and 24 that present to the Emergency Department for low acuity problems (triage level 4 and 5) because they do not have access to a primary care physician. Grace Medical Center currently operates one walk-in clinic through Grace Clinic of Lubbock. There are currently 7,070 Medicaid and uninsured Emergency Room visits annually. Out of that 7,070 patients, Grace will establish the baseline visits of patients that live in the HPSA zip codes 79412, 79404, and 79423 as the target population . There are currently approximately 61,400 people living in the target zip codes. Based on Grace's Emergency Department payor mix, Grace projects that 60% or 36,840 individuals are Medicaid or self-pay. Grace treated 5,893 patients in the ER from the targeted zip codes. Grace Medical Center will, through Grace Clinic of Lubbock, recruit 2 additional primary care providers and open a new walk-in clinic with extended hours within the HPSA.

Goals and Relationship to Regional Goals: The project goal is to provide access to primary care in the appropriate setting. The expected outcome is to reduce low level visits to the Emergency Department by the underserved self-pay and Medicaid population. Grace will expand primary care capacity by recruiting two new providers and support staff, opening a new walk-in clinic in the underserved area of the existing HPSA, establish provider and ER benchmarks, and perform a PSDA of the case management intervention and scheduling system. This project meets the Regional goal by adding additional access to primary care through a new location and new providers.

Challenges: The challenge to the accomplishment of the goal is the historic conditioning of the uninsured and Medicaid patient to present to the Emergency Room for acute primary care needs. Through neighborhood education, education provided through the Emergency Room, case management, and the ability to assign the patient to an available primary care provider at the time of the ER visit through electronic scheduling, Grace can overcome the challenge to accomplish the goal.

Five Year Expected Outcome for Provider and Patients: The 5 year expected outcome would be an increase in primary care visits over the baseline and a decrease in low acuity visits to the Emergency Room.

Starting Point/Baseline: DY1 10-01-2011 through 09-30-2011 - 12 primary care providers, baseline for new primary care visits is 52,161 as of the start of DY2 as physician will be added in DY2. Low acuity emergency visit by target population baseline will be established in DY2.

Rationale: We selected this project because Grace Medical Center is located in a Healthcare Profession Shortage Area (HPSA) serving census tracts 13, 14, 22.02, 22.04, 23 and 24. Grace Medical Center is located in census tract 23. Grace will use zip codes 79412, 79404, and 79423 in the HPSA area to define ER target population baselines. In CY2011, Grace Medical Center had 11,784 Emergency Room visits of which 36% were self-pay and 24% were Medicaid patients. In 2008, 27% of adults went to the Emergency Room for a condition that could have been treated by a regular doctor, if available. [14] Chronically ill individuals without insurance are four to six times more likely to have problems accessing care, and therefore rely on Emergency Departments for primary care.[15]

In DY1, Grace Medical Center had 8 Family Medicine physicians, 1 internal medicine physician and 3 primary care mid-level providers. The majority of these services are provided through Grace Clinic of Lubbock located at 4515 Marsha Sharp Freeway. Currently, only the Internal Medicine physician has a clinic in the HPSA (on the Grace Medical Center campus). Grace also provides 24/7 Emergency Service in the HPSA. The Emergency Room experienced 11,784 visits in in 2011 of which 24% were Medicaid and 36% were self-pay. According to the AHA Resource Center, the average cost of an ER visit in 2010 was $1,349 and the median was $607. Assignment of patients to a primary care provider is difficult due to limited acceptance of Medicaid and self-pay patients. Grace will add 2 primary care providers and open new clinic space at the hospital campus to accept assignment of patients from the ER and provide walk-in services which are projected to see 4,000 additional primary care visits over the baseline of 52,161 and reduce the low level ED visits (triage level 4 and 5) over the baseline.

Project Core Components: Grace will provide the core project components as follows: a) Expand primary care space by renovating space at the hospital campus to accommodate additional primary care; b) Expand primary care hours by providing new clinic hours through two new providers and eight new support staff members with the capacity to see an estimated 4,000 patients annually. c) Expand primary care clinic staffing (Milestone P-5. Train/hire additional primary care providers and staff and/or increase the number of

[14] Commonwealth Fund. *National Scorecard on US Health System Performance*, 2008.
[15] *Annals of Internal Medicine*, August 2008.

primary care clinics for existing providers) by adding one new provider in DY2 (Metric P-5.1.) and an additional provider in DY3 (Metric P-5.1.).

Unique Community Need Identification Numbers the Project addresses: This project will assist in meeting community need RHP12 ID # CN.1 (Severe primary care provider shortage, wait time, expense, lack of insurance, and access to care as identified by BRFSS data, focus groups, survey, and DSHS.) This project provided significant enhancements to provide primary care in the HPSA area.

Related Category 3 Outcome Measure(s):
IT-9.2 ED appropriate utilization
Process Improvement DY2 would be to establish benchmark for target population patient visits of low acuity (triage levels 4 and 5) in the ER. (P-2.) Process improvement in DY3 would be to conduct a PDSA on case management process and electronic scheduling (P-4). Improvement Target DY4 - IT 9.2, Decrease the percentage low acuity ER visits of the target population by 5% over baseline established in DY2. Improvement Target DY5 – IT 9.2, Decrease of 10% of baseline target population's low acuity in ER visits. Lack of access to primary care leads to inappropriate use of expensive ER services and lack of medical homes. The conclusion of a study published by Annals of Emergency Medicine [Ann Emerg Med. 2011;58:41-52] was "Interventions targeting frequent users may reduce ED use. Case management, the most frequently describes intervention, reduced ED costs and seemed to improve social and clinical outcomes." AHRQ Agency for Healthcare Research and Quality published in the AHRQ Health Care Innovations Exchange "Formalized, Technology-Enabled Referral Relationships Between Medical Center and Community Clinics Enhance Access and Reduce Inappropriate Emergency Department Visits." This study identified inadequate linkages between ED and primary care as a problem. "Those who present at the ED often do not follow up on suggestions to go to a community clinic (and instead return to the ED), while those able to access community-based primary care often have difficulties getting referred to needed specialists."

Relationship to other Projects: By expanding existing primary care clinics, Grace expects to refocus the delivery of healthcare in a coordinated manner that leads to a reduction in potentially preventable admissions (RD-1), potentially preventable readmission (RD-2), and potentially preventable complications (RD-3), improve patient centered healthcare (RD-4) and improve emergency department (RD-5).

Relationship to Other Performing Providers' Projects in the RHP: N/A

Plan for Learning Collaborative: Our RHP will encourage participation by all of our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project meets the RHP12 goal of Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. By providing additional primary care resources, case management, and electronic scheduling, Grace will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties. The project further develops and maintains a coordinated care delivery system. Right care improvement targets will allow better management of health in a cost effective location in a HPSA by moving patients out of low acuity ER visits into a primary care setting. There is a strong body of evidence that access to primary care and intervention in ER use improves care while reducing cost.	**5**
Addresses Community Need(s)	This project addresses RHP12's highest priority community need. Grace Medical Center is the only hospital in the community located within a HPSA. There is a strong body of evidence that access to primary care and intervention in ER use improves care while reducing cost.	**5**
Project Scope/Size	This projects targets improvement in an underserved area (HPSA) by offering primary care services in the area through recruitment of new providers and case management in the ER. Patient visits in the primary care clinic will reduce inappropriate ER visits and save substantial costs. We anticipate that we will reduce inappropriate visits of the target population by 700 visits annually. According to the AHA Resource Center, the average cost of an ER visit in 2010 was $1,349 and the median cost was $607. Grace Medical Center admits 2% of ER patients. We anticipate serving 4,000 additional primary care visits by DY5.	**5**
	This project will require substantial financial and human resource investment for an organization of this size to serve the HPSA to include o **Recruitment costs for providers (2 providers salaries, recruitment and relocation)** o **Start up operational costs (equipment, supplies, medications, furniture)** o **Staffing costs (8 support staff)** o **Case Management Costs (ER Case Manager)** o **Legal Costs (Employment contracts)** o **IT costs (Electronic Health Record software licenses, hardware)** o **Renovation costs ($50/square foot)**	**5**

281514401.1.1	1.1.2	1.1.2.A-C	Project/Intervention Title: 1.1 Expand Primary Care Capacity, Expand Existing Primary Care Capacity
Lubbock Heritage Hospital, LLC, dba Grace Medical Center			281514401
Related Category 3 Outcome Measure:	281514401.3.1	IT-9.2	ED appropriate utilization

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-5. Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers **Metric: P-5.1.** Documentation of increased number of providers and staff and/or clinic sites **Baseline:** 12 primary care providers **Goal:** Add 1 primary care provider **Data Source:** Physician Employment Contract **Estimated Milestone 1 Incentive Payment:** $574,444	**Milestone 2: P-5** Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers **Metric : P-5.1** Documentation of increased number of providers and staff and/or clinic sites **Baseline:** 13 primary care providers. **Goal**: Add 1 primary care provider **Data Source:** Physician Employment Contract/HR files for mid-level **Estimated Milestone 2 Incentive Payment:** $313,344 **Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric I-12.2** Improve the total number of unique patients encountered in the clinic for	**Milestone 4: P-4** Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: P-4.1:** Increased number of hours at primary care clinic over baseline **Goal**: Expand clinic hours over current operating hours **Baseline:** No Walk-in clinic hours at new location at the time of this project proposal. Baseline is zero hours. **Data Source**: Clinic documentation **Estimated Milestone 4 Incentive Payment:** $314,254 **Milestone 5: I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric : I-1.12.2**	**Milestone 6: I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric : I-12.2** Improve the total number of unique patients encountered in the clinic or reporting period **Baseline/Goal**: Increase primary care visits by 4,000 over the baseline of DY1 Data Source: Physician Employment Contracts/ HR files for mid-levels Estimated Milestone 5 Incentive Payment: $519,204

	reporting period **Baseline:** DY1 primary care visits. 52,161 **Goal:** Increase primary care visits by 2,000 over the baseline **Data Source:** Provider patient report from EHR Estimated Milestone 3 Incentive Payment: $313,344	Improve the total number of unique patients encountered in the clinic or reporting period **Baseline/Goal:** Baseline is DY1 primary care visits. Increase primary care visits by 3,500 over the baseline **Data Source**: Provider patient report from EHR Estimated Milestone 5 Incentive Payment: $314,254	
DY 2 Estimated Milestone Bundle Amount: $574,444	DY 3 Estimated Milestone Bundle Amount: $626,688	DY4 Estimated Milestone Bundle Amount: $628,509	DY5 Estimated Milestone Bundle Amount: $519,204
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,348,845			

Project Option: ***1.1.2 Expand Primary Care Capacity, Expand existing primary care capacity***

Performing Provider: Lamb Healthcare Center/127313803

RHP Unique Identification Number: 127313803.1.1

Provider: Lamb Healthcare Center is a 75 bed licensed sole community hospital (staff for 42 beds) in Littlefield, Texas, serving a town of approximately 6,300 people and 13,977 in Lamb County. We also receive patients from other surrounding counties such as Hockley, Bailey, Cochran, Castro and Lynn.
Intervention: This project will add a primary care physician to LHC Family Medicine's clinic in order to provide better, more efficient, more convenient, primary care for our community and surrounding areas.
Need for the project: In Lamb County, the low income, uninsured, and minority populations are higher than the state average. Our percentage of people living below the poverty level is 16.9%, which is higher than the state average of 14.3%. Of this population, persons without insurance <18 is 19.6% vs. the state average of 19.5%, and persons <65 without insurance is 28.4% vs the average of 26.8%. The non-white or minority population of the county is approximately 56.9%. Our population for 65+ is 15.9% and our death rate per 100,000 for Heart Disease is at 345.0 vs the state 154.0. When residents were asked about chronic diseases in the household; 22% reported a household member with some form of heart disease. This is the reason we have chosen CHF as our Cat 3 outcome measure.
Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting periods have significant impact on patient and provider satisfaction and quality of care, and discourage people from using healthcare proactively. Low income people are also less likely to have the availability of resources to travel, therefore, if they are not able to get an appointment locally, they will probably be forced to ignore the care they need.
In addition, due to low or negative operating margins of public hospitals, we are relatively disadvantaged in physician recruiting.
Expected outcome is increasing the availability of primary care providers in LHC Family Medicine's clinic in order to provide better, more efficient, more convenient, primary care for our community and surrounding areas.
Target Population: Our target population consists of a town of approximately 6,300 people and 13,977 in Lamb County. We also receive patients from other surrounding counties such as Hockley, Bailey, Cochran, Castro and Lynn. With the poverty level being 16.9% in Lamb County, we feel as though all of our population, including the Medicaid and indigent populations, will benefit from this project by providing local healthcare when people are not able to travel. As of last year (YE 9/30/12) our Medicaid, Indigent, and Uninsured percentage for Hospital admissions was approximately 42% of all admissions. This does not include people that are unable to pay high deductibles on their insurance premiums.
Category 2 expected patient benefits: This project seeks to provide 46 more visits per month (560 per year) in DY3, 70 more visits per month (840 per year) in DY4, and 93 more visits per month (1120 per year) in DY 5. With the addition of a primary care physician, patients will have a stable medical home and continuity of care will increase the health of our community.
Category 3 outcomes: IT-2.1 Congestive Heart Failure Admission rate (CHF**)** Our goal is to decrease admission rate by a percent TBD from baseline data established in DY2.

Project Option: ***1.1.2 Expand Primary Care Capacity, Expand existing primary care capacity***

Performing Provider: Lamb Healthcare Center/127313803

RHP Unique Identification Number: 127313803.1.1

Project Option: 1.1.2.a-c

Project Description:

Our goal is to increase LHC's ability to treat more patients in the primary care setting where they can

receive more preventative and proactive care more efficiently. The primary goal is to increase LHC's primary capacity in order to better accommodate the needs of our patient population.

In Lamb County, the low income, uninsured, and minority populations are higher than the state average. Our county population is 13,977. Our percentage of people living below the poverty level is 16.9%, which is higher than the state average of 14.3%. Of this population, persons without insurance <18 is 19.6% vs. the state average of 19.5%, and persons <65 without insurance is 28.4% vs the average of 26.8%. The non-white or minority population of the county is approximately 56.9%. Our population for 65+ is 15.9% and our death rate per 100,000 for Heart Disease is at 345.0 vs the state 154.0. When residents were asked about chronic diseases in the household; 22% reported a household member with some form of heart disease. This is the reason we have chosen CHF as our Cat 3 outcome measure.

Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting periods have significant impact on patient and provider satisfaction and quality of care, and discourage people from using healthcare proactively. Low income people are also less likely to have the availability of resources to travel, therefore, if they are not able to get an appointment locally, they will probably be forced to ignore the care they need.

In addition, due to low or negative operating margins of public hospitals, we are relatively disadvantaged in physician recruiting.

Our expected outcome is increasing the availability of primary care providers in LHC Family Medicine's clinic in order to provide better, more efficient, more convenient, primary care for our community and surrounding areas.

By expanding primary care clinic staffing, we are better able to address the needs of our community. Our five year expected outcome is to be able to accommodate the needs of the patient population so they are better able to receive the right care at the right time in the right setting and provide patients with more preventative and proactive care regardless of their ability to pay.

Region 12 regional goals are to address as many of the community needs in the community needs assessment as possible. We are focusing on the most critical need established by our community. In addressing this need, we are partnering with the region in meeting the needs of our community.

Starting Point/Baseline: 1167 Visits per month (Sept 2012)

Rationale:
We have chosen this project due to the extreme shortage of primary care providers our area. Project components are: a) Expand primary care clinic space - we already have clinic space available and are not expanding space. b) Expand primary clinic hours – we are not expanding hours at this time due to the shortage of physicians and staff it would take to achieve this. We do not feel as though this is a priority at this time. c) Expand primary care clinic staffing – this will be fulfilled by hiring a primary care physician and staff to provide care for patients in our community. Milestones for this project will be (I-12) to increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Our metric will be (I-12.1.a) Documentation of increased number of visits. Total number of visits for reporting period. Our milestones and metrics are relevant to our community need due to our Physicians/100,000 residents being 19.1 vs. the rural total of 38.9, and the urban total of 73.4. Again, our project focuses on the most critical need determined by our community needs assessment and our RHP 12 Needs Assessment Summary. This results in patients receiving services in urgent or emergent care settings for conditions that could be better managed in a primary care setting. By adding a new primary care physician and staff we will be enhancing primary care points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Unique community needs identification number:
CN.1. Severe primary care provider shortage, wait time, expense, lack of insurance, access to care

Related Category 3 Outcome Measure(s):
Congestive Heart Failure Admission rate (CHF) – IT-2.1. Review chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. The chronic care model has helped hundreds of providers improve care for people with chronic conditions. Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients.91 Also, an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained

one or more chronic care model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).92 Also, it has been shown that "planned care for all" can be more effective than "disease-silo" care. For example, the Cherokee Nation adopted a systems approach to diabetes care in 2002, which included many of the concepts in the Improving Patient Care (IPC) change package, such as patient and population management by registered nurse diabetes care managers; evidence-based guidelines; planned visits; care by a multidisciplinary team; diabetes self-management support and education; use of registries for population management; and data driven improvement, resulting in improved diabetes care and intermediate outcomes. Monitor all non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF.[16]

Relationship to other Projects: This project meets the highest community need identified (CN.1) which addresses the shortage of primary care providers. By providing another PCP, we will have more physicians to see the patients that have poor insurance support or are uninsured (CN.3). A new PCP will also help provide maternal and prenatal care for patients in our community (CN.5) since we seek to hire Family Practice/OB physicians. In the past, we had more physicians and were able to provide care for more patients in our community. Project 1.1 will help us fulfill our Cat 3 outcome measure IT 2.1 by improving access to primary care physicians so patients are better able to get help managing their CHF with the right care at the right time in the right setting.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all of our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

[16] http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2008%20CHF%20Admission%20Rate.pdf

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	In Lamb County, the low income, uninsured, and minority populations are higher than the state average. Those individuals often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute conditions putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long wait times have significant negative impact on patient and provider satisfaction and quality of care, and discourage people from using healthcare proactively. Low income people are less likely to have the availability of resources to travel, therefore, if they are not able to get an appointment locally, they will probably be forced to ignore the care they need. By having an additional provider in the local clinic, we will be able to provide better, more efficient, more convenient, primary care for our community and surrounding areas.	**5**
Addresses Community Need(s)	This project meets the highest community need identified (CN.1), which addresses the shortage of primary care providers. By providing another PCP, we will have more physicians to see the patients that have poor insurance support or are uninsured (CN.3). A new PCP will also help provide maternal and prenatal care for patients in our community (CN.5) since we seek to hire Family Practice/OB physicians. In the past, we had more physicians and were able to provide care for more patients in our community.	**5**
Project Scope/Size	As mentioned above, we expect to reach all patients in our community regardless of their ability to pay. We expect to increase our patient encounters and provide service to as many people as possible in our community so they are do not have to travel. We expect patients will be able to take care of their needs locally where they can receive the right care in the right setting at the right time.	**5**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have enough physicians to ensure our patients are seen in an appropriate setting when they need care. Our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all the staff needed and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**5**

127313803.1.1	**1.1.2**	**1.1.2.a-c**	**Expand Primary Care Capacity, Expand Existing Primary Care Capacity**
Lamb County Healthcare Center		**127313803**	
Related Category 3 Outcome Measure:	**127313803.3.1**	**IT-2.1**	**Congestive Heart Failure Admission rate(CHF)**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P5] Hire additional Primary Care Provider and Staff **Metric 1:[P5.1]:** Documentation of increased number of providers and staff **Baseline/Goal**: Add one primary care provider to current staff. **Data Source:** Clinic monthly report on office visits. Milestone 1 Estimated incentive payment: $344,870	**Milestone 2: I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1: I-12.1:** Documentation of increased number of visits. Total number of visits for reporting period. **Baseline/Goal:** 1167 visits per month (September 2012 amount) Increase by 560 added visits per year over baseline for DY3 **Data Source:** Clinic monthly report on office visits. Milestone 2 Estimated incentive payment: $399,749	**Milestone 3: I-12}** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1 [12.1.a]:** Documentation of increased number of visits. Total number of visits for reporting period. **Baseline/Goal:** 1167 visits per month (September 2012 amount) Increase by 840 added visits per year over baseline for DY4 **Data Source:** Clinic monthly report on office visits. Milestone 3 Estimated incentive payment: $403,881	**Milestone 4: [I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services] **Metric 1 [I-12.1a]:** Documentation of increased number of visits. Total number of visits for reporting period. **Baseline/Goal:** 1167 visits per month (September 2012 amount) Increase by 1120 added visits per year over baseline for DY5 **Data Source:** Clinic monthly report on office visits. Milestone 4 Estimated incentive payment: $346,036
DY 2 Estimated Total DSRIP Funding: $344,870	**DY 3 Estimated DSRIP Funding:** $399,749	**DY4 Estimated Total DSRIP Funding:** $403,881	**DY5 Estimated Total DSRIP Funding:** $346,036
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,494,536			

Project Title: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.

Performing Provider: Medical Arts Hospital/189947801

RHP Unique Identification Number: 189947801.1.1

Project components: 1.7.1.e-f

Provider: Dawson County Hospital District dba as Medical Arts Hospital is a 22-bed facility in Lamesa, Texas. This rural facility serves a 40 miles radius including the counties of Dawson, Terry, Lynn, Borden and Gaines. Located in Dawson County, population 14,000, Medical Arts Hospital's total market area draws from as many as 51,000 patients. The closest large medical center is approximately 1 hour away, making our rural hospital a vital tertiary hospital for residents in our region. Data in our Community Needs Assessment indicates that Dawson County has 3,736 unduplicated Medicaid Clients. That means 27% of our residents are receiving Medicaid, a fact that ranks us in the top tier of counties with needy families. Medicaid charges comprise approximately 28% of all Medical Arts Hospital business.

Interventions: This project will implement a telemedicine program in the Specialty Clinic to provide expanded specialty referral services and expanded access for rural residents.

Need for the project: Patients in Dawson County must travel two hours, round trip, to see specialists in Lubbock or Midland. For many of our Medicare/Medicaid patients, that burden is too great. They forego or delay treatment from a specialist, making it more difficult for them to effectively manage chronic conditions. This project in many cases will remove the barrier created by our remote location.

Target population: Our target population is established cardiology patients being seen for routine appointments through telemedicine. We selected established cardiology patients because we do not want a patient's initial visit with the cardiologist to be through telemedicine. Once a patient has seen the cardiologist in person, they will be eligible to see the physician via telemedicine for continued care. Approximately 20% of our target population is comprised of Medicaid eligible or indigent patients.

Category 1 or 2 expected patient benefits: The baseline for this project is zero patients served through telemedicine. Our plan to increase cardiology consults performed via telemedicine by 24 telemedicine visits over baseline in DY 3, 72 telemedicine visits over baseline in DY4 and 144 telemedicine visits over baseline in DY5 for our targeted population of established cardiology patients. Our target population of established cardiology patients being seen for routine appointments in 2011 was 330 patients. Of those patients, approximately 40% of those are on Medicare and 20% are Medicaid patients. Therefore, of the 144 visits increased, 86 visits will be for Medicare/Medicaid patients. In our estimation, this waiver project will impact 108 patients total and 65 of those patients will be Medicare/Medicaid We expect that the expanded access and convenience will allow our Medicare/ Medicaid patients the ability to more effectively manage chronic conditions.

Category 3 outcomes: IT-6.1 Patient Satisfaction Our goal is to improve patient satisfaction scores among target population of established cardiology patients receiving routine care at the clinic through telemedicine. Patients will be asked to complete the CAHPS® Clinician & Group Surveys - 12-Month Survey 2.0 (Adult) including the supplemental module "Your Care From Specialists in the Last 12 Months." As our team conducts the planning for this survey, they may add specific questions to the core and supplemental surveys. Amount of improvement TBD in DY2.

Project Title: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.
Performing Provider: Medical Arts Hospital/189947801
RHP Unique Identification Number: 189947801.1.1
Project components: 1.7.1. a-b

- **Project Description:** Medical Arts will implement a telemedicine program in the Specialty Clinic to provide expanded specialty referral services for Dawson County. The goals of this project are: 1. Increase patient access to specialty care through the use of telemedicine. 2. Increase patient access to a broader range of specialties through the use of telemedicine. Dawson County's challenges are familiar to other rural communities in our region. Medicare and Medicaid patients in rural areas have decreased access to specialty care, both in the number of physicians and specialties offered. Patients in Dawson County must travel two hours, round trip, to see specialists in Lubbock or Midland. For many of our Medicare/Medicaid patients, that burden is too great. They forego or delay treatment from a specialist, making it more difficult for them to effectively manage chronic conditions. This project in many cases will remove the barrier created by our remote location. Patients will be able to receive their specialty care in their home community. The expected outcome is that greater access to care will yield better and less costly outcomes for chronically ill Medicare/Medicaid patients. Our target population is established cardiology patients being seen for routine appointments through telemedicine. We selected established cardiology patients because we do not want a patient's initial visit with the cardiologist to be through telemedicine. Once a patient has seen the cardiologist in person, they will be eligible to see the physician via telemedicine for continued care. The five year expected outcome will create benefits for Medical Arts Hospital in the form of more patients seen in a timely manner, less-costly outcomes and increased patient satisfaction. In the next five years, patients can expect to reap the cost savings associated with not having to travel to receive their specialty care. They will enjoy healthier outcomes and find more satisfaction in the convenience offered by timely visits with their specialist. Region 12 goals are based on the needs expressed in the Community Needs Assessments from each County including Dawson County. Expanded access to specialty care is one of Dawson County's greatest need and therefore is addressed by Region 12 Community Needs Identifier CN. 5

- **Starting Point/Baseline:** Telemedicine is a new program for Medical Arts Hospital. Baseline is zero patients served.

- **Rationale:** This project was selected because it represents a great need in Dawson County. Access to specialty care physicians was listed as one of our top priorities in the Dawson County Community Needs Assessment and is ranked as CN.5 in Region 12's assessment. Telemedicine in our specialty clinic will open our community to a broad range of specialties we would not be able to

offer otherwise. In addition, it creates expanded appointment availability for our highest volume specialty, Cardiology. For the purpose of this Waiver, we have chosen to focus on Cardiology patients. Our program will achieve both of the core project components. We will (a) provide patient consultations by medical and surgical specialists as well as other types of health professionals using telecommunications. Our hospital plans to lease a telemedicine unit from Texas Tech. This unit will allow us to connect our cardiologists with local patients for follow-ups or consultations. This partnership with Texas Tech will also give us access to the network of specialists in the telemedicine program at the University Health Sciences Center. We will also accomplish (b) conduct quality improvement for project using methods such as rapid cycle improvement. Our planning team will be connected through a group e-mail where problems and needs for improvement can be immediately discussed and solved as a team. The results of these improvements will be shared with other hospitals in RHP 12 at the twice yearly learning collaborative. RHP 12 will participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. These actions will satisfy Process Milestone (P-11). The implementation of telemedicine in our specialty clinic (P-3) will happen in DY2 through a relationship with Texas Tech University Health Sciences Center. We will have access to their entire network of specialists including our targeted specialty, Cardiology. We chose this milestone (P-3) in DY2 because it matched our desire to begin this program as soon as possible in order to meet the documented need for expanded access for Cardiac patients in Dawson County. Our improvement milestone for the waiver is (I-12) to increase the number of telemedicine visits for our target population by 15% over baseline in DY5. We chose this milestone because our main goal is to increase access and we feel this can best be demonstrated by increasing the number of telemedicine consults. Our target population is established cardiology patients being seen for routine appointments through telemedicine. In 2011, we saw 330 of our target population cardiology patients in in the specialty clinic with one physician coming one day per month. This physician averages 27 patients a day each time he visits our community. Our Community Needs Assessment states that in rural counties, like ours, 25% of households reported having a family member with some form of heart disease. In additions, Dawson County's mortality rate from Heart Disease is almost double the State average. (258.4 deaths per 100,000 population as opposed to 154 per 100,000 population in Texas.) Starting with a baseline of zero cardiology patients receiving telemedicine consults, we plan to increase that by 24 telemedicine visits over baseline in DY 3, 72 telemedicine visits over baseline in DY4 and 144 telemedicine visits over baseline in DY5 for our targeted population of established cardiology patients. Our target population of established cardiology patients being seen for routine appointments in 2011 was 330 patients. Of those patients, approximately 40% of those are on Medicare and 20% are Medicaid patients. Therefore, of the 144 telemedicine visits, 86 visits will be for Medicare/Medicaid patients. In our estimation, this waiver project will impact 108 patients total and 65 of those patients will be Medicare/Medicaid This is a completely new initiative for this community and will require a great deal of education for our population that is older and less technically savvy. We understand that telemedicine is a priority issue for the U.S. Department of Health and Human Services, but we are not receiving any

other funds related to offering this project. Expanded access to specialty care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.5.

- **Related Category 3 Outcome Measure(s):** This project and its milestones will yield an outcome in OD-6 Patient Satisfaction, IT-6.1., which is a stand-alone measure. We selected this outcome measure because the satisfaction of our patients is a chief priority for our hospital. We believe that the convenience provided by being able to see the specialist in town, via telemedicine, will lead to patients seeing their physician more regularly to manage their chronic conditions. This will yield healthier outcomes and higher patient satisfaction. Patients who are satisfied with their health care services are more engaged and better equipped to manage a chronic condition. Patients will be asked to complete the CAHPS® Clinician & Group Surveys - 12-Month Survey 2.0 (Adult) including the supplemental module "Your Care From Specialists in the Last 12 Months." As our team conducts the planning for this survey, they may add specific questions to the core and supplemental surveys. The demographics in our Community Needs Assessment state that patients in Dawson County are older, sicker and poorer than the State average. Managing chronic conditions is paramount for Dawson County where our mortality rates for breast cancer, colon cancer, heart disease, lung cancer and stroke are more than double the State average. All of these factors make travel to receive healthcare more difficult. That's why this project, the milestones and the outcome measures make sense for our community.

- **Relationship to other Projects:** This project is closely related to our other project (1.7.2). Both involve the use of technology with established evidence-based successes in providing increased access and higher quality health care. Both projects target cardiac patients. Although both projects are worthy and supported with Community Needs, we believe this project (1.7.1) will impact more patients and create a greater shift in healthcare than will 1.7.2. This plan does not relate to any Category 4 projects because our hospital chose not to participate in Category 4. Medical Arts Hospital was exempted due to our size.

- **Relationship to Other Performing Providers' Projects in the RHP: see next item**

- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to- face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	We valued this project as a 5 because it achieves the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. It will provide a great deal of impact for Medicaid and uninsured residents who have trouble traveling great distances to seek specialty care. For our targeted population, this project will move the dial greatly. Telemedicine has been widely studied and proven to show strong evidence that it achieves the triple aim.	**5**
Addresses Community Need(s)	We valued this project as a 4 because in relation to our other project it very effectively matches our Community Needs. Improving access to specialty care physicians in order to better manage chronic conditions was our number one Community Need. For the patients who use the telemedicine in the specialty clinic, their ability to manage their chronic condition will improve greatly. By removing the need to make expensive travel to see a cardiologist, low-income patients will see their physician more regularly and be more compliant. Telemedicine has been widely studied and proven to show strong evidence that it achieves the triple aim.	**4**
Project Scope/Size	In relation to our other project, this project will serve a larger population. Not only will it provide greater access to specialty care for cardiac patients, it will bring dozens of other greatly needed specialties to our community. We believe that increasing the local access to a cardiologist for our low-income patients will increase their ability to receive regular care to manage a chronic illness. These increased patient visits/encounters will yield better outcomes for the patients, saving both the patient and federal government.	**5**
Project Investment	In relation to our other project, this project provides the much desired pairing of cost-effective and highly impactful. It will provide services that “move the dial” while not requiring a great deal of capital. It can be implemented fairly quickly and is in line with the priorities of our organization.	**5**

189947801.1.1	1.7.1	1.7.1.a-b	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.
Medical Arts Hospital			**189947801**
Related Category 3 Outcome Measure(s):	**189947801.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores. Provider will use CAHPS® Clinician & Group Surveys - 12-Month Survey 2.0 (Adult) including the supplemental module "Your Care From Specialists in the Last 12 Months."**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-3] Implement or expand telemedicine program for established cardiology patients receiving routine care in the Specialty Clinic. **Metric 1: [3.1]:** Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR docs. **Goal:** Successful implementation of telemedicine program Data Source: Program materials **Estimated Milestone 1 Incentive Payment:** $107,617 **Milestone 2: [P-11]** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: [P-11.1]:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in meetings	**Milestone 3: [I-12]** Increase number of telemedicine visits for established cardiology patients receiving routine care in the Specialty Clinic. **Metric 1: [-I-12.1]:** Number of telemedicine visits for established cardiology patients receiving routine care in the Specialty Clinic. **Baseline/Goal:** Baseline is zero patients served with telemedicine. Increase telemedicine visits by 24 visits over baseline for established cardiology patients receiving routine care in the Specialty Clinic. **Data Source:** EHR or electronic referral processing system, encounter records from telemedicine program. **Estimated Milestone 3 Incentive Payment:** $124,742 **Milestone 4: [P-11]** Participate in face-to-face learning with other	**Milestone 5: [-I-12]** Increase number of telemedicine visits for established cardiology patients receiving routine care in the Specialty Clinic. **Metric 1: [I-12.1]:** Number of telemedicine visits for established cardiology patients receiving routine care in the Specialty Clinic. **Baseline/Goal:** Baseline is zero patients served with telemedicine. Increase telemedicine visits by 72 visits over baseline for established cardiology patients receiving routine care in the Specialty Clinic. **Data Source:** EHR or electronic referral processing system, encounter records from telemedicine program. **Estimated Milestone 5 Incentive Payment:** $126,031.50 **Milestone 6: [P-11]** Participate in	**Milestone 7: [I-12]** Increase number of telemedicine visits for established cardiology patients receiving routine care in the Specialty Clinic. **Metric 1: [I-12.1]:** Number of telemedicine visits for established cardiology patients receiving routine care in the Specialty Clinic. **Baseline/Goal:** Baseline is zero patients served with telemedicine. Increase telemedicine visits by 144 visits over baseline for established cardiology patients receiving routine care in the Specialty Clinic. **Data Source:** EHR or electronic referral processing system, encounter records from telemedicine program. **Estimated Milestone 7 Incentive Payment:** $107,981

189947801.1.1	1.7.1	1.7.1.a-b	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.
Medical Arts Hospital			**189947801**
Related Category 3 Outcome Measure(s):	**189947801.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores. Provider will use CAHPS® Clinician & Group Surveys - 12-Month Survey 2.0 (Adult) including the supplemental module "Your Care From Specialists in the Last 12 Months."**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 2 Incentive Payment:** $107,617	providers in RHP with similar projects. **Metric 1: [P-11.1]:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 4 Incentive Payment:** $124,742	face-to-face learning with other providers in RHP with similar projects. **Metric 1: [P-11.1]:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 6 Incentive Payment:** $126,031.50	**Milestone 8: [P-11]** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: [P-11.1]:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 8 Incentive Payment:** $107,981
DY 2 Estimated Milestone Bundle Amount: $215,234	**DY 3 Estimated Milestone Bundle Amount** $249,484	**DY4 Estimated Milestone Bundle Amount:** $252,063	**DY5 Estimated Milestone Bundle Amount:** $215,962
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:$932,743			

Project Option: 1.7.2 **Implement remote patient monitoring programs for diagnosis and/or management of care. Providers should demonstrate that they are exceeding the requirements of the EHR incentive program.**

Performing Provider: Medical Arts Hospital/189947801

RHP Unique Identification Number: 189947801.1.2

Provider: Dawson County Hospital District dba as Medical Arts Hospital is a 22-bed facility in Lamesa, Texas. This rural facility serves a 40 miles radius including the counties of Dawson, Terry, Lynn, Borden and Gaines. Located in Dawson County, population 14,000, Medical Arts Hospital's total market area draws from as many as 51,000 patients. The closest large medical center is approximately 1 hour away, making our rural hospital a vital tertiary hospital for residents in our region. Data in our Community Needs Assessment indicates that Dawson County has 3,736 unduplicated Medicaid Clients. That means 27% of our residents are receiving Medicaid, a fact that ranks us in the top tier of counties with needy families. Medicaid charges comprise approximately 28% of all Medical Arts Hospital business.

Interventions: This project will implement a tele-monitoring program for cardiac patients requiring 24/7 monitoring in their homes through Medical Arts Hospital Home Health Care. This project is expected to impact 18 patients, 14 patients will likely be Medicare/Medicaid or indigent.

Need for the project: Dawson County's challenges are familiar to other rural communities in our region. Our patients are older, sicker and often require increased education and extended monitoring. Dawson County's mortality rate for cardiac issues is twice the State average. The large number of chronically ill patients has provided more demand than can be met by our current health care team. This project will provide efficiencies for our Home Health department, making it easier for them to meet the demand for monitoring cardiac patients. But more importantly, tele-monitoring will provide a greater level of care and peace of mind for our cardiac patients for who informed assistance is just a phone call away.

Target population: Our target population is cardiac patients who require 24/7 monitoring in home. We expect to see better outcomes, peace of mind, increased satisfaction and fewer admissions to the hospital. Approximately 20% of our Home Health population is Medicaid eligible or indigent. Another 60% are Medicare patients.

Category 1 or 2 expected patient benefits: Our improvement milestone for the waiver is (I-12) to increase the number patients in our target population using in-home tele-monitoring by 4 patients in DY3 and increase that to 10 patients in DY 4 and end the waiver period with 18 patients served in DY5.83% of all our Home Health patients are Medicare/Medicaid. Therefore, we expect that 14 of the patients receiving a tele-monitoring unit will be Medicare/Medicaid patients. Starting with the baseline of zero home health cardiac patients all improvement milestones will be expressed over baseline. Although the milestone stipulates number of visits, we are modifying that to demonstrate the increased number of users. Because this service is available 24/7, it is hard to clarify the number of "visits" performed by the health care team. We chose this milestone because our

main goal is to increase the quality of the monitoring for our cardiac patients and we feel this can best be demonstrated by increasing the number of patients using the in-home tele-monitoring.

Category 3 outcomes: IT-3.2 -CHF 30 Day Readmission Rates- Medical Arts Hospital will sample CHF 30-day Readmission Rates among cardiac patients using Home Health prior to introducing tele-monitoring to establish baseline. After the introduction of tele-monitoring, we will compare the CHF 30-day readmission rate of members of the target population (cardiac patients requiring 24/7 monitoring in home through Home Health) who have used tele-monitoring to see to what impact tele-monitoring has had on CHF 30-day Readmission Rates. We expect to decrease in CHF 30-Day Readmission among target population of cardiac patients needing 24/7 monitoring in-home through Home Health. Amount of improvement TBD in DY2

Project Option: 1.7.2 **Implement remote patient monitoring programs for diagnosis and/or management of care. Providers should demonstrate that they are exceeding the requirements of the EHR incentive program.**
Performing Provider: Medical Arts Hospital/189947801

RHP Unique Identification Number: 189947801.1.2

- **Project Description:** Medical Arts Hospital will implement a tele-monitoring program for cardiac patients requiring 24/7 monitoring in their homes. Medical Arts Home Health will monitor these patients. The goal of this project is to provide a patient-centered approach to healthcare where real/near-time monitoring and interaction with a health care team can potentially address patient problems before they require major interventions. Dawson County's challenges are familiar to other rural communities in our region. Our patients are older, sicker and often require increased education and extended monitoring. Dawson County's mortality rate for cardiac issues is twice the State average. The large number of chronically ill patients has provided more demand than can be met by our current health care team. This project will provide efficiencies for our Home Health department, making it easier for them to meet the demand for monitoring cardiac patients. But more importantly, tele-monitoring will provide a greater level of care and peace of mind for our cardiac patients for who informed assistance is just a phone call away. The expected outcome is that the higher quality of monitoring for chronically ill cardiac patients will yield a decrease in 30 day admissions for CHF patients at Medical Arts Hospital. The five year expected outcome will create benefits for Medical Arts Hospital in the form of more patients seen in a timely manner, less-costly outcomes and increased patient satisfaction. In the next five years, our target population (cardiac patients who require 24/7 monitoring in home) can expect to see better outcomes, peace of mind, increased satisfaction and fewer admissions to the hospital. Region 12 goals are based on the needs expressed in Community Needs Assessments from each County including Dawson County. Higher quality of care for our large chronically ill cardiac population is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

- **Starting Point/Baseline:** A Tele-monitoring program for cardiac patients who require 24/7 monitoring does not exist at Medical Arts Hospital. Baseline is zero patients served. We expect to serve 18 patients through this project.

- **Rationale:** This project was selected because it represents a great need in Dawson County. Higher quality of care for our large chronically ill cardiac population is a top priority in the Dawson County Community Needs Assessment and is ranked as CN.1 in Region 12's assessment. Tele-monitoring cardiac patients in their home will provide our Home Health department with real-time access to their vital statistics, improving the quality of their care and addressing small issues before they require major intervention. As part of our plan, we will introduce the tele-monitoring units in the homes of cardiac patients who require a greater level of monitoring than we can provide traditionally. We plan to start with 4 patients in DY3 and increase that to 10 patients in DY 4 and

end the waiver period with 18 patients served in DY5. In 2011, our population of cardiac patients monitored by Home Health was 308 patients. Cardiac patients represent more than 50% of all Home Health patients total. 83% of all our Home Health patients are Medicare/Medicaid. Therefore, we expect that 14 of the patients receiving a tele-monitoring unit will be Medicare/Medicaid patients.

Our Community Needs Assessment states that in rural counties, like ours, 25% of households reported having a family member with some form of heart disease. In addition, Dawson County's mortality rate from heart related diseases is almost double the State average, (258.4 deaths per 100,000 population as opposed to 154 per 100,000 in Texas.) We will accomplish our five year waiver goals through the use of milestones. Milestone 1 is P-5, implement remote patient monitoring program based on evidence-based medical specialties such as Home Health. We chose this milestone (P-5) in DY2 because it matched our desire to begin this program as soon as possible in order to meet the documented need for a greater level of quality in the monitoring of our cardiac patients. Since this is a new program, we will benefit greatly from Process Milestone (P-11) where-in we will participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Our improvement milestone for the waiver is (I-12) to increase the number patients in our target population using in-home tele-monitoring by 18 patients. Although the milestone stipulates number of visits, we are modifying that to demonstrate the increased number of users. Because this service is available 24/7, it is hard to clarify the number of "visits" performed by the health care team. We chose this milestone because our main goal is to increase the quality of the monitoring for our cardiac patients and we feel this can best be demonstrated by increasing the number of patients using the in-home tele-monitoring. This is a completely new initiative for this community and will require a great deal of education for our population that is older and less technically savvy. We understand that telemedicine is a priority issue for the U.S. Department of Health and Human Services, but we are not receiving any other funds related to offering this project. Improving the quality of monitoring for cardiac patients is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

Core Component: We will accomplish the core component for CQI by conducting rapid cycle improvement. Our planning team will be connected through a group e-mail where problems and needs for improvement can be immediately discussed and solved as a team. The results of these improvements will be shared with other hospitals in RHP 12 at the twice yearly learning collaborative. RHP 12

Related Category 3 Outcome Measure(s): This project and its milestones will yield an outcome in OD- 3 Potentially Preventable Readmissions – 30 day Readmission rates, IT-3.2, which is a stand-alone measure. We selected this outcome measure because improving the quality of monitoring for our cardiac patients and their outcomes is of vital importance in a County where our patients

are twice as likely to die from heart related diseases as others in the State of Texas. We believe that focusing on 30 day readmission rates for CHF patients will give us a solid way to measure if the tele-monitoring intervention has been successful in helping our patients more effectively manage this chronic disease. This project will provide a patient-centered approach to healthcare where real/near-time monitoring and interaction with a health care team member can potentially address patient problems before they require major interventions, such as readmission to the hospital. The demographics in our Community Needs Assessment state that patients in Dawson County are older, sicker and poorer than the State average. Managing chronic conditions is paramount for Dawson County where our mortality rates for breast cancer, colon cancer, heart disease, lung cancer and stroke are more than double the State average. Improving the quality of the monitoring we offer these patients will make a significant difference for our most vulnerable cardiac patients. That's why this project, the milestones and the outcome measures make sense for our community.

- **Relationship to other Projects:** This project is closely related to our other project (1.7.1). Both involve the use of technology with established evidence-based successes in providing increased access and higher quality health care. Both projects target cardiac patients. Although both projects are worthy and supported with Community Needs, we believe this project (1.7.2) will impact fewer patients but will create a significant difference for the patients who do receive in-home monitoring. This plan does not relate to any Category 4 projects because our hospital chose not to participate in Category 4. Medical Arts Hospital was exempted due to our size.

- **Relationship to Other Performing Providers' Projects in the RHP: see next item**

- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to- face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	We valued this project as a 3 because while it does achieve the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way, it doesn't impact as large a population as our other project (1.7.1). It achieves all of the four stated waiver goals. It will provide a great deal of impact for the few Medicaid and uninsured patients who receive tele-monitoring in their home. For our targeted population, this project will move the dial greatly. Tele-monitoring has been widely studied and proven to show strong evidence that it achieves the triple aim.	**3**
Addresses Community Need(s)	We valued this project as a 2 because tele-monitoring was not specifically listed in our Dawson County Community Needs Assessment. However, improving the quality of care for those with chronic diseases was our greatest need and we believe this project will serve that need. Because it will impact a small population, it was graded lower than our other project (1.7.1).	**2**
Project Scope/Size	In relation to our other project, this project will serve a smaller population. This project was scored a 3 because it will achieve a great deal of outreach to our target population of cardiac patients that require 24/7 monitoring. Through the use of technology, a health-care professional can "be there" for the patient in a matter of seconds. It will provide 24/7 real time monitoring which is hard to equate to patient visits/encounters. We believe this project will lead to cost savings by preventing unnecessary ER visits and hospitalizations.	**3**
Project Investment	In relation to our other project, this project is more expensive and it impacts a smaller population. The cost of the in-home monitoring equipment and staff will be more extensive. This project also carries with it a greater risk for hospital, staff and patients. It will require an enormous amount of education to make sure that physicians feel comfortable with the results and patients understand how to utilize the equipment.	**3**

189947801.1.2	1.7.2	CQI	Implement remote patient monitoring programs for diagnosis and/or management of care. Providers should demonstrate that they are exceeding the requirements of the EHR incentive program.
Medical Arts Hospital			**189947801**
Related Category 3 Outcome Measure(s):	**189947801.3.2**	**IT-3.2**	**Congestive Heart Failure 30 day readmission rate**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-3] Implement or expand tele-monitoring program for cardiac patients requiring 24/7 monitoring in-home through Home Health. Metric 1: [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR docs. Goal: Successful implementation of tele-monitoring program. Data Source: Program materials Estimated Milestone 1 Incentive Payment: $69,634.50 Milestone 2: [P-11] Participate in face-to-face learning with other providers in RHP with similar projects. Metric 1: [P-11.1]: Participate in semi-annual face to face meetings or	Milestone 3: [-I-12] Increase number of tele-monitoring patients from among target population of cardiac patients requiring 24/7 monitoring in-home through Home Health. Metric 1: [I-12.1]: Number of tele-monitoring patients from among target population of cardiac patients requiring 24/7 monitoring in-home through Home Health. Baseline/Goal: Baseline is zero patients served with tele-monitoring. Increase tele-monitoring patients to 4 over baseline. Data Source: EHR or electronic referral processing system, encounter records from tele-monitoring program Estimated Milestone 3 Incentive Payment: $80,715.50 Milestone 4: [P-11] Participate in	Milestone 5: [I-12] Increase number of tele-monitoring patients from among target population of cardiac patients requiring 24/7 monitoring in-home through Home Health. Metric 1: [I-12.1]: Number of tele-monitoring patients from among target population of cardiac patients requiring 24/7 monitoring in-home through Home Health. Baseline/Goal: Baseline is zero patients served with tele-monitoring. Increase tele-monitoring patients to 10 over baseline. Data Source: EHR or electronic referral processing system, encounter records from tele-monitoring program Estimated Milestone 5 Incentive Payment: $81,549.50 Milestone 6: [P-11] Participate in	Milestone 7: [I-12] Increase number of tele-monitoring patients from among target population of cardiac patients requiring 24/7 monitoring in-home through Home Health. Metric 1: [I -12.1]: Number of tele-monitoring patients from among target population of cardiac patients requiring 24/7 monitoring in-home through Home Health. Baseline/Goal: Baseline is zero patients served with tele-monitoring. Increase tele-monitoring patients to 18 over baseline. Data Source: EHR or electronic referral processing system, encounter records from tele-monitoring program Estimated Milestone 7 Incentive Payment: $69,870 Milestone 8: [P-11] Participate in

189947801.1.2	1.7.2	CQI	Implement remote patient monitoring programs for diagnosis and/or management of care. Providers should demonstrate that they are exceeding the requirements of the EHR incentive program.
Medical Arts Hospital			**189947801**
Related Category 3 Outcome Measure(s):	**189947801.3.2**	**IT-3.2**	**Congestive Heart Failure 30 day readmission rate**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
seminars organized by the RHP Goal: Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes Estimated Milestone 2 Incentive Payment: $69,634.50	face-to-face learning with other providers in RHP with similar projects. Metric 1: [P-11.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP Goal: Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes Estimated Milestone 4 Incentive Payment: $80,715.50	face-to-face learning with other providers in RHP with similar projects. Metric 1: [P-11.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP Goal: Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes Estimated Milestone 6 Incentive Payment: $81,549.50	face-to-face learning with other providers in RHP with similar projects. Metric 1: [P-11.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP Goal: Participation in meetings offered by the RHP. Data Source: Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes Estimated Milestone 8 Incentive Payment: $69,870
DY 2 Estimated Milestone Bundle Amount: $139,269	DY 3 Estimated Milestone Bundle Amount: $161,431	DY4 Estimated Milestone Bundle Amount: $163,099	*DY5 Estimated Milestone Bundle Amount: $139,740*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $603,539			

Project Option Title: 1.1 Expand Existing Primary Care Capacity
Performing Provider: Medical Arts Hospital/189947801
RHP Unique Identification Number: 189947801.1.4 – **"PASS 3"**

Provider: Dawson County Hospital District dba as Medical Arts Hospital is a 22-bed facility in Lamesa, Texas. This rural facility serves a 40 miles radius including the counties of Dawson, Terry, Lynn, Borden and Gaines. Located in Dawson County, population 14,000, Medical Arts Hospital's total market area draws from as many as 51,000 patients. The closest large medical center is approximately 1 hour away, making our rural hospital a vital tertiary hospital for residents in our region. Data in our Community Needs Assessment indicates that Dawson County has 3,736 unduplicated Medicaid Clients. That means 27% of our residents are receiving Medicaid, a fact that ranks us in the top tier of counties with needy families. Medicaid charges comprise approximately 28% of all Medical Arts Hospital business.

Interventions: Medical Arts will address core component (b) to expand primary care clinic hours. At this time we are planning to operate a Saturday clinic from 9 am till 1 pm. If there is great demand for these services we may further extend our Saturday hours, add a physician on Saturday and may consider an evening clinic during the week. The minimum number of physician hours we plan to add is 16 hours per month (excluding June, July, August.) This would yield an increase in 576 physician hours over the life of the waiver. Our clinic is less than 2 years old and is the appropriate size, therefore we will not address core component a) expand primary clinic space. Our clinic is appropriately staffed as well. The increased hours offered by the clinic will not necessitate increased staff. Therefore, we will not be addressing core component c) increased primary clinic staff.

Need for the project Dawson County is classified as a Medically Underserved Area in Texas. In October of 2012, we had 7 physicians and one mid-level serving the family practice needs of a county population of 13,833 citizens. Our county population is older than the state average. In addition, the per capita income level of $27,409 puts Dawson County in the top tier of counties with needy families and 42.2% of our citizens are without health insurance. The average monthly Medicaid Enrollment is 3,159, meaning that a full 27% of our residents are receiving Medicaid. Dawson County has a high rate of uncompensated charity care. Uncompensated care accounts for 19.5% of our hospital's gross revenue.

Target population: Our target population is Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours.

Category 1 or 2 expected patient benefits: Our goal is to see 12 patients every Saturday (excluding Saturdays in June, July and August) in DY 2. This will yield an increase of 48 encounters per month or 432 increased visits for DY2. In DY3, we will add 576 visits. In DY4, 648 visits will be added and in DY5, 900 visits will be added. That would mean that an additional 2556 visits would be offered over the life of the waiver. It is conceivable that more than 2000 people could be served. Approximately 20-30% of these additional visits will be experienced by Medicaid or indigent patients.

Category 3 outcomes: IT-9.2 ED Appropriate Utilization. In DY2 we will work to establish a baseline of ED visits attributed to our target population prior to the commencement of the clinic's extended hours. We will compare the same hours of the day. Example: We will look at the average ED usage Saturday mornings from 9 am- 1 pm attributed to our target population prior to the opening of our Saturday primary care clinic then we will compare it to the same hours to see how many visits are attributed to our target population after the Saturday clinic was established. In DY3 we will engage in

project planning (P-1). Beginning in DY 4, we will focus on Improvement Target (IT-9.2) that will reduce all ED visits during the time the primary care clinic is open during extended hours. We will continue to reduce those visits in DY5 by a percentage that is TBD in DY2.

Project Option Title: 1.1 Expand Existing Primary Care Capacity

Performing Provider: Medical Arts Hospital/189947801

RHP Unique Identification Number: 189947801.1.4 – **"PASS 3"**

Project Components: [b] Expand Primary Care clinic hours

- **Project Description:** Medical Arts Hospital will increase access to Primary Care by providing extended hours in the Primary Care Clinic. The goals of this project are: 1. Increase patient access to primary care through the addition of extended hours. 2. Decrease ED utilization during the clinic's extended hours, providing right care at the right time in the right setting for patients with urgent care needs. Dawson County's challenges are familiar to other rural communities in our region. Patients in rural areas have decreased access to primary care physicians. Dawson County is classified as a Medically Underserved Area in Texas. In October of 2012, we had 7 physicians and one mid-level serving the family practice needs of a county population of 13,833 citizens. Our county population is older than the state average. In addition, the per capita income level of $27,409 puts Dawson County in the top tier of counties with needy families and 42.2% of our citizens are without health insurance. The average monthly Medicaid Enrollment is 3,159, meaning that a full 27% of our residents are receiving Medicaid. Dawson County has a high rate of uncompensated charity care. Uncompensated care accounts for 19.5% of our hospital's gross revenue. Not only are our citizens older and poorer than the State average, they are also sicker. Dawson County citizens with chronic diseases are twice as likely to die from heart disease, breast cancer and stroke. The result of all this County data is that the demands for health care, especially primary care offered in the right setting, is more than we can handle in our current clinic with current hours.
  The target population for this project [1.1.2] is Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours. The five year expected outcome will create benefits for Medical Arts Hospital in the form of more patients seen in the right setting, less-costly outcomes, decreased ED utilization for non-emergent illnesses and increased patient satisfaction. In the next five years, patients will benefit from the convenience of these extended clinic hours making it easier for them to establish a relationship with a primary care physician in a medical home model. Region 12 goals are based on the needs expressed in the Community Needs Assessments from each County including Dawson County. Expanded access to Primary Care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN. 1.

  Starting Point/Baseline: In September 2012 the Primary Clinic had 2209 encounters. We will use this as our baseline number before the start of the additional hours on Saturday began in October 2012. The Saturday clinic hours will allow our clinic to conduct an additional 2556 visits over the life of this waiver period.
- **Rationale:** This project was selected because it represents a great need in Dawson County. Access to primary care physicians was listed as one of our top priorities in the Dawson County Community Needs Assessment and is ranked as CN.1 in Region 12's

assessment. Extended hours in our clinic will provide increased access for our County Population, of which 25% is receiving Medicaid and for our target population. Our program will achieve one of the core project components. We will (b) expand primary care clinic hours. At this time we are planning to operate a Saturday clinic from 9 am till 1 pm. If there is great demand for these services we may further extend our Saturday hours, add physicians on Saturday and may consider an evening clinic during the week. We are not able to address core components (a) expand primary care clinic space and (c) expand primary care clinic staffing in this waiver project. Our clinic is less than 2 years old and is the appropriate size, therefore we will not address core component a) expand primary clinic space. Our clinic is appropriately staffed as well. The increased hours offered by the clinic will not necessitate increased staff. Therefore, we will not be addressing core component c) increased primary clinic staff. We will measure our project using process milestone (P-4), expand the hours of a primary care clinic over baseline. At this time we plan to expand our hours by 16 per month. We will grow the number of extended hours as demand increases. We will use Improvement Milestone (I-12), increase primary care clinic volume of visits and evidence of improved access for patients seeking services. We will use Metric (I-12.1) which is documentation of increased number of visits, demonstrating improvement over prior reporting period. We will additionally conduct quality improvement for the project using methods such as rapid cycle improvement. This will be accomplished through face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

The expansion of hours in the Primary Care clinic, including evening and/or weekend hours (P-4) will happen in DY2. We will begin by adding a Saturday clinic from 9 am till 1 pm. This walk-in clinic will be staffed by one physician. It is our goal to see at least 12 patients every Saturday during those four hours. We chose this milestone (P-4) in DY2 because it matched our desire to begin this program as soon as possible in order to meet the documented need for expanded access for Primary Care in Dawson County. Our improvement milestone for the waiver is (I-12), to increase primary care clinic volume of visits and evidence of improved access for patients seeking service by 900 visits over baseline in DY5. We chose this milestone because our main goal is to increase access and we feel this can best be demonstrated by increasing the number of clinic hours to meet the needs of our target population. Our target population is Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours. Our goal is to see 12 patients every Saturday (excluding Saturdays in June, July and August) in DY 2. This will yield an increase of 48 encounters per month or 432 increased visits for DY2. In DY3, we will add 576 visits. In DY4, 648 visits will be added and in DY5, 900 visits will be added. That would mean that an additional 2556 visits would be offered over the life of the waiver. The minimum number of physician hours we plan to add is 16 hours per month (excluding June, July, August.) This would yield an increase in 576 physician hours over the life of the waiver. Approximately 20-30% of these additional visits will be experienced by Medicaid or indigent patients.

This is a completely new initiative for this community and will require a great deal of education for our population that has a pattern of using the ED for primary care. We understand that expanding primary care is a priority issue for the U.S. Department of Health

and Human Services, but we are not receiving any other funds related to offering this project. Expanded access to primary care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

- **Related Category 3 Outcome Measure(s):** This project and its milestones will yield an outcome in OD-9 Right Care, Right Setting (IT-9.2)We selected this outcome measure because the usage of our Emergency Department is unusually high. In 2010, Medical Arts Hospital had 7,882 ED visits. We know that many of these were for non-emergent conditions that should be taken care of in the clinic. We believe that we will see a reduction in ED visits during the time when clinic hours are extended. Patients will elect to seek care for non-emergent conditions in the clinic instead of utilizing the ED. Physicians and staff will be trained in how to triage patients with non-emergent conditions who do present at the ED. After an official triage in the ED, the physician will inform the patient that the clinic is open at this time and that treatment for a non-emergent condition should be sought there. This will help our target population, of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours; establish a relationship with a physician in our clinic. This will help these patients establish a medical home for their family, breaking the cycle of improper utilization of the ED. In DY2 we will work to establish a baseline of ED visits attributed to our target population prior to the commencement of the clinic's extended hours. We will compare the same hours of the day. Example: We will look at the average ED usage Saturday mornings from 9 am- 1 pm attributed to our target population prior to the opening of our Saturday primary care clinic then we will compare it to the same hours to see how many visits are attributed to our target population after the Saturday clinic was established. In DY3 we will engage in project planning (P-1). Beginning in DY 4, we will focus on Improvement Target (IT-9.2) that will reduce all ED visits during the time the primary care clinic is open during extended hours. We will continue to reduce those visits in DY5 by a percentage that is TBD in DY2. Our target population includes a large number of uninsured and Medicaid patients. We believe these extended clinic hours paired with culturally sensitive education and direction from the ED will move the dial greatly for this target population. That is why this project, the milestones and the outcome measures make sense for our community.

- **Relationship to other Projects:** This project relates to our project **189947801.1.3** ***Expand Specialty Care Access*** because both projects seek to expand access to medical care. When we accomplish both of these projects we will have significantly impacted the continuity of care for our Medicaid, uninsured and indigent patients. They will receive the right care in the right setting and then follow up with a specialist all in their hometown.

- **Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they

have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to- face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5	We valued this project as a 5 because it achieves the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. It will provide a great deal of impact for Medicaid and uninsured residents who do not have a medical home and utilize the ED for primary care. For our targeted population of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours, this project will move the dial greatly. Extended hours in the clinic will allow them the opportunity to choose to seek the right care in the right setting.	**5**
Addresses Community Need(s) Scale: 1 to 5	We valued this project as a 5 it is our only project in this Pass 3 submission. Improving access to primary care physicians through the use of expanded clinic hours meets a great Community Need. This will help our target population, of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours; establish a relationship with a physician in our clinic. This will help these patients establish a medical home for their family, breaking the cycle of improper utilization of the ED. Expanded clinic hours will achieve the triple aim of providing high-quality, patient centered care in the most cost effective way.	**5**
Project Scope/Size Scale: 1 to 5	This project is rated a five due to the fact that it is our only project in Pass 3. This project will impact a great number of patients in our target population. By the end of the waiver period we expect that extra 900 patient visits per year will be offered through extended clinic hours. These clinic hours will directly benefit uninsured and Medicaid patients who may be receiving their primary care in the Emergency Department. These 900 extra visits will move the dial greatly for these most vulnerable members of our community who need a stable medical home.	**5**
Project Investment Scale: 1 to 5	This project provides the much desired pairing of cost-effective and highly impactful. It will provide services that “move the dial” without requiring a great deal of capital. This project is done using resources we already have. It can be implemented fairly quickly and is in line with the priorities of our organization.	**5**

189947801.1.4 – "PASS 3"	1.1.2	1.1.2 b	Expand Primary Care Capacity
Medical Arts Hospital		**189947801**	
OD-9	**189947801.3.4**	**IT-9.2**	**ED Appropriate Utilization**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [1.1.2-P-4] Expand the hours of a primary care clinic, including evening and/or Weekend hours. **Metric 1**: [1.1.2 P-4.1]: Increased number of hours at primary clinic over baseline. **Goal:** Successfully increase clinic hours over baseline. **Data Source:** Clinic Documentation **Estimated Milestone 1 Incentive Payment:** $22,959.33 **Milestone 2**: [1.1.2-I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1**: [1.1.2-I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Baseline is total number of visits in September 2012. 2209 visits. Goal over to increase the number of visits by 432 over baseline by serving our target population of Dawson County patients seeking	**Milestone 2:** [1.1.2-I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** [1.1.2-I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal**: Increase visits by 576 over baseline (2209 visits) by serving our target population of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours **Data Source:** EHR , claims or other Performing Provider source **Estimated Milestone 2 Incentive Payment:** $38,214 **Milestone 3:** P-X: Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1:** P-X.1: Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers.	**Milestone 2:** [1.1.2-I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** [1.1.2-I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 648 over baseline (2209 visits) by serving our target population of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours **Data Source:** EHR , claims or other Performing Provider source **Estimated Milestone 2 Incentive Payment:** $36,741.50 **Milestone 3:** P-X: Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1:** P-X.1: Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers.	**Milestone 2:** [1.1.2-I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** [1.1.2-I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 900 over baseline(2209 visits) by serving our target population of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours **Data Source: EHR** , claims or other Performing Provider source **Estimated Milestone 2 Incentive Payment:** $30,265 **Milestone 3:** P-X: Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1:** P-X.1: Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face

primary care for a non-emergent illness during the extended clinic hours **Data Source**: EHR , claims or other Performing Provider source **Estimated Milestone 2 Incentive Payment:** $22,959.33 **Milestone 3:** P-X: Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1:** P-X.1: Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 3 Incentive Payment:** $22,959.33	**Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 3 Incentive Payment:** $38,214	**Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 3 Incentive Payment:** $36,741.50	learning with other providers. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 3 Incentive Payment:** $30,265
DY 2 Estimated Milestone Bundle Amount: $68,878	**DY 3 Estimated Milestone Bundle Amount** $76,428	**DY4 Estimated Milestone Bundle Amount:** $73,483	**DY5 Estimated Milestone Bundle Amount:** $60,530
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:$279,319			

***Project Option: 1.9.2* Improve access to specialty care.**
Performing Provider: Medical Arts Hospital/189947801
RHP Unique Identification Number: 189947801.1.5 – "PASS 3b"
Project Components: 1.9.2.a-d

Provider: Dawson County Hospital District dba as Medical Arts Hospital is a 22-bed facility in Lamesa, Texas. This rural facility serves a 40 miles radius including the counties of Dawson, Terry, Lynn, Borden and Gaines. Located in Dawson County, population 14,000, Medical Arts Hospital's total market area draws from as many as 51,000 patients. The closest large medical center is approximately 1 hour away, making our rural hospital a vital tertiary hospital for residents in our region. Data in our Community Needs Assessment indicates that Dawson County has 3,736 unduplicated Medicaid Clients. That means 27% of our residents are receiving Medicaid, a fact that ranks us in the top tier of counties with needy families. Medicaid charges comprise approximately 28% of all Medical Arts Hospital business.

Interventions: Medical Arts will improve access to specialty care services by expanding the available space in the clinic and the available number of hours for patients to be seen in the specialty clinic.

Need for the project: Dawson County's challenges are familiar to other rural communities in our region. Uninsured and Medicaid patients in rural areas have decreased access to specialty care, both in the number of physicians and specialties offered. Patients in Dawson County must travel two hours, round trip, to see specialists in Lubbock or Midland. For many of our uninsured/Medicaid patients, that burden is too great. They forego or delay treatment from a specialist, making it more difficult for them to effectively manage chronic conditions. This project, in many cases, will remove the barrier created by our remote location. Patients will be able to receive specialty care in their home community. The current Medical Arts Specialty Clinic is far too small to meet the demand for services.

Target population: Our target population is Dawson County patients who choose to seek specialty care from a physician in our specialty clinic rather than choosing to travel to another clinic. Our target population is broad. It encompasses anyone who uses our specialty clinic. This underscores the broad effect this project will have on the lives of patients and families in our community**.**

Category 1 or 2 expected patient benefits: For the purpose of targeting our growth in DY4 and DY5, we calculated our growth based on encounter data in the specialty clinic from 10-1-11 /10-31-12. In that year, the clinic conducted 1899 visits.. We plan to increase in DY4 by 759 specialty care visits over baseline to be set in DY2. In DY5, we plan to increase by an additional 1139 visits over DY2 baseline. By the end of this waiver approximately 1139 more visits will be accomplished and our target population will have seen a specialty physician in their hometown and saved themselves the financial and physical burden of 2 hours of travel. Approximately 20-30% of these additional visits will be experienced by Medicaid or indigent patients.

Category 3 outcomes: IT-6.1 Patient Satisfaction We expect to see improvement in patient satisfaction scores among target population: Dawson County patients choosing to seek specialty care at Medical Arts Specialty clinic rather than traveling to another clinic Amount of improvement TBD in DY2.

Medical Arts Hospital will sample patient satisfaction scores in our target population to establish a baseline. After the launch of the expanded specialty care clinic, we will survey members of the target population who have used the expanded clinic to see to what impact that has had on patient satisfaction.

Project Option: 1.9.2 **Improve access to specialty care.**
Performing Provider: Medical Arts Hospital/189947801
RHP Unique Identification Number: 189947801.1.5 – "PASS 3b"
Project Components: 1.9.2.a-d

Project Description: Medical Arts will improve access to specialty care services by expanding the available space in the clinic and the available number of hours for patients to be seen in the specialty clinic. The goals of this project are: 1. Increase patient access to specialty care 2. Increase patient access to a broader range of specialties. As part of this project, Medical Arts will relocate the specialty clinic into a much larger clinic that is adjacent to the primary care clinic. The new larger space will effectively double the number of treatment rooms, making it possible for more than one specialty physician to operate at a time. This will increase the number of hours open for appointments. The increased space will allow us to recruit desperately needed specialties to our community like: podiatry, rheumatology, diabetes care management including foot care and gynecology.

Medical Arts Hospital will make a capital investment of 1.12 million dollars to build the new specialty clinic onto the current rural health clinic. The planned square footage will be 5,764 square feet. In contrast, the current specialty clinic operates in a building that is less than 2,000 square feet. . The new clinic is designed to allow two physicians to work at the same time. In that arrangement each physician has 4 exam rooms each. The clinic also allows the flexibility for one physician to work alone and use all eight rooms. This will greatly assist our high volume specialties. The new clinic will have a treatment room dedicated to tele-medicine. The specialty clinic will also house a large room for community education. This facility should break ground in the second quarter of 2013 and be completed in 1 year.

In addition to doubling the clinic's capacity, Medical Arts Hospital will be hiring a full-time Specialty Clinic Case Manager to increase referral coordination for primary care and medical specialty clinics. This specialized Case Manager will be the key to insuring that our patients are receiving the most direct, patient-centered care. Dawson County's challenges are familiar to other rural communities in our region. Uninsured and Medicaid patients in rural areas have decreased access to specialty care, both in the number of physicians and specialties offered. Patients in Dawson County must travel two hours, round trip, to see specialists in Lubbock or Midland. For many of our uninsured/Medicaid patients, that burden is too great. They forego or delay treatment from a specialist, making it more difficult for them to effectively manage chronic conditions. This project, in many cases, will remove the barrier created by our remote location. Patients will be able to receive specialty care in their home community. The current Medical Arts Specialty Clinic is far too small to meet the demand for services. It provides a visiting physician with only 3 treatment rooms and a waiting room that is 10 x 10 sq. ft. On days when our high-volume specialists are present, as many as 30-40 patients are seen in this tiny space. On these days, every room is filled, every chair in the waiting room is occupied and patients stand and wait until one becomes available. This lack of space has greatly hindered our growth.

The expected outcome is that greater access to care will yield better and less costly outcomes for chronically ill uninsured/Medicaid patients. Our target population is Dawson County patients who choose to seek specialty care from a physician in our specialty clinic rather than choosing to travel to another clinic. Our target population is broad. It encompasses anyone who uses our specialty clinic. This underscores the broad effect this project will have on the lives of patients and families in our community**.** The five year expected outcome will create benefits for Medical Arts Hospital in the form of more patients seen in a timely manner, less-costly outcomes and increased patient satisfaction. In the next five years, patients can expect to reap the cost savings associated with not having to travel to receive their specialty care. They will enjoy healthier outcomes and find more satisfaction in the convenience offered by timely visits with their specialist. Region 12 goals are based on the needs expressed in the Community Needs Assessments from each County including Dawson County. Expanded access to specialty care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN. 1.

Starting Point/Baseline: The planning protocol states that we will improve over a baseline set in DY2. For the purpose of targeting our growth in DY4 and DY5, we calculated our growth based on encounter data in the specialty clinic from 10-1-11 /10-31-12. In that year, the clinic saw 1899 patients. . In that year, the clinic conducted 1899 visits. We plan to increase in DY4 by 759 specialty care visits over baseline to be set in DY2. In DY5, we plan to increase by an additional 1139 visits over DY2 baseline. By the end of this waiver approximately 1139 more visits will be accomplished and our target population will have seen a specialty physician in their hometown and saved themselves the financial and physical burden of 2 hours of travel. Approximately 20-30% of these additional visits will be experienced by Medicaid or indigent patients.

Rationale: This project was selected because it represents a great need in Dawson County. Access to specialty care physicians was listed as one of our top priorities in the Dawson County Community Needs Assessment and is ranked as CN.1 in Region 12's assessment. Expansion of our specialty clinic will open our community to a broad range of specialties we would not be able to offer otherwise. In addition, it creates expanded appointment availability for our highest volume specialties; Cardiology, Dermatology and Gynecology. This project will significantly enhance our current services providing a level of care that has never been seen in Dawson County. Our program will achieve all four of the core project components. We will (a) provide increased service availability with extended hours. We will do this by expanding the space so that we have two physicians practicing at the same time. This expansion will double the number of available service hours. We will also accomplish (b) increasing the number of specialty clinic locations. We will trade a grossly undersized clinic for a clinic twice the size. We will more than double the treatment space. The addition of a full-time Specialty Clinic Case Manager will help us address (c) implementation of transparent, standardized referrals across the system. And lastly, we will accomplish (d) conducting quality

improvements for the project using methods such as rapid cycle improvements. We will do these through our participation in a learning collaborative with other providers in our region with a similar project. These activities are also addressed in our plan through process measure

(P-21) where-in we will participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. The expansion of specialty care capacity will be accomplished through these process and improvement measures. In DY2 we will train care providers and staff on processes, guidelines and technology for referrals (P-2). In DY2 we will also begin to participate in face-to-face learning with other providers in RHP with similar projects. We will continue this milestone (P-21) throughout the four years of this waiver. We chose these milestones in DY2 because they matched our need to learn from others and educate our own staff in how we can streamline the referral process in order to make the continuum of care seamless for our patients. In DY3 we plan to open our expanded specialty clinic. Not only will the clinic be twice the size of our current facility, it will be adjacent to our primary care clinic. We feel that the close proximity to one another will foster greater communication between the primary physician and staff and the specialty physician and staff. In DY4 we will begin focusing on our improvement milestone for the waiver, (I-23) to increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. We chose this milestone because our main goal is to increase access and we feel this can best be demonstrated by increasing the number of specialty visits .We will track our target population which is Dawson County patients choosing to see a specialty physician at the Medical Arts Specialty Clinic rather than travel to another clinic. The planning protocol states that we will improve over a baseline set in DY2. For the purpose of targeting our growth in DY4 and DY5, we calculated our growth based on encounter data in the specialty clinic from 10-1-11/10-31-12. In that year the clinic saw 1899 patients. We plan to increase that 40% or 759 specialty care visits in DY 4. In DY5, we plan to see an additional 1139 patients per year for an increase of 60%. We understand that expanding specialty care capacity is a priority issue for the U.S. Department of Health and Human Services, but we are not receiving any other funds related to offering this project. Expanded access to specialty care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

Related Category 3 Outcome Measure(s): This project and its milestones will yield an outcome in OD-6 Patient Satisfaction. We selected this outcome measure because the satisfaction of our patients is a chief priority for our hospital. We believe that the convenience provided by being able to see the specialist in town will lead to patients seeing their physician more regularly to manage their chronic conditions. This will yield healthier outcomes and higher patient satisfaction. Patients who are satisfied with their health care services are more engaged and better equipped to manage a chronic condition. The demographics in our Community Needs Assessment state that patients in Dawson County are older, sicker and poorer than the State average. Managing chronic conditions is paramount for Dawson County where our mortality rates for breast cancer, colon cancer, heart disease, lung cancer and stroke are more than double the State average. All of these

factors make travel to receive healthcare more difficult. That's why this project, the milestones and the outcome measures make sense for our community.

Relationship to other Projects: This project is closely related to a project in our Pass 1 submission. Our plan to increase access to specialty care through the use of telemedicine in the specialty clinic can only be accomplished in this new building.(1.7.1)**189947801.1.1** also addresses the need to increase access to specialty care. That project is targeted at cardiac patients. This project (1.9.2) **189947801.1.3** will reach more patients and move the dial for uninsured and Medicaid patients who don't want to travel to see their specialty physician. Both projects are worthy and supported with Community Needs.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to- face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	We valued this project as a 5 because it achieves the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. It will provide a great deal of impact for Medicaid and uninsured residents who have trouble traveling great distances to seek specialty care. For our targeted population, this project will move the dial greatly. Increased access to specialty care has been widely studied and proven to show strong evidence that it achieves the triple aim.	**5**
Addresses Community Need(s)	We valued this project as a 5 because it very effectively matches our Community Needs. Improving access to specialty care physicians in order to better manage chronic conditions was our number one Community Need. For the patients who see physicians in our specialty clinic, their ability to manage their chronic condition will improve greatly. By removing the need to make expensive travel to see a specialist, low-income patients will see their physician more regularly and be more compliant. Improved access to specialty care achieves the triple aim.	**5**
Project Scope/Size	This project will serve a large number of patients in Dawson County. In 2012, 1899 patients were seen in our small rural specialty clinic. Not only will it provide greater access to specialty care for patients, it will give us the opportunity to expand our space so we can include greatly needed specialties to our community. We believe that increasing the local access to a specialty physician for our low-income patients will increase their ability to receive regular care to manage a chronic illness. These increased patient visits/encounters will yield better outcomes for the patients, saving both the patient and federal government.	**5**
Project Investment	This is our only project in Pass 2, therefore it was rated a 5. This project will require a large amount of capital to achieve the goal of doubling our specialty care clinic capacity. It will provide services that “move the dial” for our target population and for the uninsured/Medicaid population. This project will remove barriers to specialty care, provide choice and provide care that is patient centered.	**5**

189947801.1.5 – "PASS 3b"	**1.9.2**	**1.9.2.a-d**	**Improve access to specialty care**
Medical Arts Hospital			**189947801**
Related Category 3 Outcome Measure(s):	**189947801.3.5**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores. Provider will use CAHPS® Clinician & Group Surveys - 12-Month Survey 2.0 (Adult) including the supplemental module "Your Care From Specialists in the Last 12 Months."**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1 P-2: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. **Metric 1 P-2.1:** Training of staff and providers on referral guidelines, process and technology **Goal:** Successful training of providers and staff **Data Source**: Log of specialty care personnel trained and Curriculum for training. **Estimated Milestone 1 Incentive Payment:** $128,935 **Milestone 2:** P-21: Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1:** P-21.1: Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers. **Data Source:** Documentation of	**Milestone 3: P-11**: Launch/expand a specialty care clinic **Metric 1: P-11.1:** Establish/expand specialty care clinics **Goal:** Successful expansion of specialty care clinic **Data Source:** Documentation of new/expanded specialty care clinic **Estimated Milestone 3 Incentive Payment**: $143,069 **Milestone 4: P-21:** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-21.1:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting	**Milestone 5: I-23:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1: [I-23.1]:** Documentation of increased number of visits. Demonstrate improvement over baseline for DY2 **Baseline/Goal:** Baseline for year ending 10/31/12is 1899 visits in the specialty clinic. Baseline for DY2 is yet to be determined. Goal is to increase specialty care visits among our target population: Dawson County patients choosing to see a specialty physician at the Medical Arts Specialty Clinic rather than travel to another clinic, by 759 visits over DY2 baseline (TBD). **Data Source:** EHR claims or other Performing Provider source. **Estimated Milestone 5 Incentive Payment:** $137,556.50	**Milestone 7: [I-23]** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1: [I-23.1]:** Documentation of increased number of visits. Demonstrate improvement baseline for DY2) **Baseline/Goal:** Baseline for year ending 10/31/12is 1899 patients in the specialty clinic. Baseline for DY2 is yet to be determined. Goal is to increase specialty care visits among our target population, Dawson County patients choosing to see a specialty physician at the Medical Arts Specialty Clinic rather than travel to another clinic, by 1139 visits over DY2 baseline (TBD) **Data Source:** EHR claims or other Performing Provider source. **Estimated Milestone 7 Incentive Payment:** $113,309

189947801.1.5 – "PASS 3b"	**1.9.2**	**1.9.2.a-d**	**Improve access to specialty care**
Medical Arts Hospital			**189947801**
Related Category 3 Outcome Measure(s):	**189947801.3.5**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores. Provider will use CAHPS® Clinician & Group Surveys - 12-Month Survey 2.0 (Adult) including the supplemental module "Your Care From Specialists in the Last 12 Months."**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 2 Incentive Payment:** $128,935	notes. **Estimated Milestone 4 Incentive Payment:** $143,069	**Milestone 6: P-21:** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-21.1:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 6 Incentive Payment:** $137,556.50	**Milestone 8: P-21:** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-21.1:** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Goal:** Participation in face-to-face learning with other providers. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 8 Incentive Payment:** $113,309
DY 2 Estimated Milestone Bundle Amount: $257,870	DY 3 Estimated Milestone Bundle Amount $286,138	DY4 Estimated Milestone Bundle Amount: $275,113	*DY5 Estimated Milestone Bundle Amount: $226,618*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:$1,045,738			

Project Option: 1.1.2 Expand Primary Care Capacity, Expand Existing Primary Care Capacity
***Performing Provider*: Memorial Hospital/094121303**
Unique Project ID: 094121303.1.1
***Project Components:* 1.1.2.a-c**

- **Provider:** Seminole Hospital District, dba, Memorial Hospital is the sole healthcare provider in rural Gaines County, Texas. Memorial Hospital is a Critical Access hospital serving a population of approximately 17,500. The District as a whole provides healthcare services which include Home Health, Hospice, Provider Assistance, Assisted Living, Long-term Care, a wellness center, two provider based clinics as well as general hospital acute care services.

- **Intervention(s):** This project will add a primary care provider thus expanding the opportunity to provide patient care to the community.

- **Need for Project**: The county population has steadily increased over the last 10 years while the number of primary care providers has remained stagnant. Due to the lack of primary care access many in our community, especially Medicaid and uninsured, are utilizing the emergency room for primary care services.

- **Target Population:** This project will target the low income, uninsured and minority populations in our community. This target population represents over 50% of the county's population.

- **Category 1 Expected Patient Benefits:** This project seeks to provide 4,500 primary care clinic encounters during the length of the DSRIP project. In DY 3 we expect to increase primary care visits by 2,000 over baseline, in DY 3increase primary care visits by 3,500 over baseline and in DY 5 increase primary care visits by 4,500 over baseline. We project that 40% (1,800) of these primary care patients will be Medicaid or uninsured.

- **Category 3 Outcomes:** IT 1.11 Our goal is to increase the number of diabetic patients whose blood pressure is controlled by 20% over baseline in DY40% over baseline in DY5.

Project Option: 1.1.2 Expand Primary Care Capacity, Expand Existing Primary Care Capacity
***Performing Provider*: Memorial Hospital/094121303**
Unique Project ID: 094121303.1.1
***Project Components:* 1.1.2.a-c**

Project Description:

Memorial Hospital proposes to expand existing primary care capacity, expand primary care clinic space, and expand primary care clinic staffing.

Seminole Hospital District, dba, Memorial Hospital is the sole healthcare provider in rural Gaines County, Texas. Memorial Hospital is a Critical Access hospital serving a population of approximately 17,500. The District as a whole provides healthcare services which include Home Health, Hospice, Provider Assistance, Assisted Living, Long-term Care, a wellness center, two provider based clinics as well as general hospital acute care services.

This project will target the low income, uninsured and minority populations in our community. In Gaines County, approximately 18.7% of the population is below the poverty line. Approximately 40% of our county residents are uninsured. These populations present a challenge to providing quality health care in our community. Individuals from these various groups often have multiple chronic conditions, prevalent in our community - diabetes. Without regular primary care, these conditions become acute episodes putting these patients at risk for disability and premature death. To address these challenges and issues, Memorial Hospital will expand existing primary care capacity, Category 1, Project Option 1.1.2, by adding a primary care provider. Adding a primary care provider (PCP) will accommodate the needs of this population so they receive the right care at the right time and in the right setting. Expanding primary care capacity will also provide an opportunity for increased preventative healthcare and improve health outcomes. This project will impact one clinic.

Project implementation team members will include the Chief Executive Officer, responsible for recruitment and provider contract negotiations, the Chief Financial Officer, responsible for the financial and accounting aspects of the clinic and project reporting and the Clinic Manager who is responsible for hiring the necessary staff and managing the clinic operations. In DY2 we will hire a primary care provider, milestone P.5 and re-purpose an existing building to expand clinic space, milestone P.1. In DY3, we propose to implement a process to measure patient satisfaction, improvement milestone I.11, and increase primary care clinic volume, improvement milestone I.12. Reporting on these two improvement milestones will begin in DY3.

Project Goals:

The overarching goal of our project is to improve access to and quality of primary care. We propose to increase care capacity by 25% across the 5 year project (4,500 patient primary care encounters), improve patient health outcomes, improve quality of care, improve patient satisfaction and reduce the amount of primary care provided in the emergency room. We expect to impact 1,800 Medicaid or uninsured patients.

Challenges:

A significant challenge for this project is attracting and retaining a primary care provider. A rural community typically appeals to only a few primary care providers, thus limiting an already dwindling pool of providers. Providing financial support is a means to attract a provider. Additional challenges include outreach to the target population and patient education and the patient's participation in maintaining a healthy lifestyle. A variety of practices will be used to reach this population including, assistance with obtaining a primary care appointment for patients seen in the ER, interpreters to address language barriers, follow-up calls from the clinic and appointment reminders.

5 year Expected Outcome for Provider and Patients:

Memorial Hospital expects to expand access to primary care by increasing the number of primary care visits for the targeted population by 25% across the 5 year project. In addition, we expect to improve patient satisfaction through implementation of a patient satisfaction survey. And we expect to improve patient health outcomes by capturing, monitoring and educating diabetic patients regarding blood pressure and the effects of high blood pressure.

Relationship to Regional Goals:

Our project meets regional goals to develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region. This project will help the region transform health care to a patient-centered, coordinated delivery model that improves patient satisfaction and health care outcomes. Our project meets a critical need identified in our regional needs assessment and our local needs assessment.

Starting Point/Baseline:

The baseline for this project is 4 providers in DY2 with a goal of 5 providers by the end of DY2.

Rationale:

In the last 10 years, the population in Gaines County has increased 8.8% while the number of primary care providers has remained stagnant. As a result, primary care access is not readily available and many in our community are utilizing the emergency room for primary care. A review of Memorial Hospitals 2011 and 2012 emergency room usage revealed 80% of ER visits as "clinic" in nature i.e. non-urgent and non-emergent. Another trend in our community results from patients foregoing preventative care and later presenting to the ER in significant need. If treated at the on-set, in a primary care setting, more than half of the urgent/emergent cases could have been avoided. Given the socio-economic status of our community, chronic diseases, such as diabetes, COPD, and CHF are prevalent. Adult and childhood obesity and diabetes are prime health concerns in our area. According to the Centers for Disease Control, Gaines County age adjusted, diagnosed diabetes patients is 9.2%. While slightly lower than the State percentage of 9.8%, complications from lack of primary and preventative diabetic care are commonly seen in our hospital. In our local community needs assessment, developed April 2012, the predominant need expressed was access to primary care. In the regional community needs assessment, primary care access was identified as a critical need.

The selected milestones and metrics support our project as they are necessary to the development, implementation and success of the project, which addresses the population and circumstances of our community and region.

Project Components:

By expanding access to primary care, we propose to meet the required project core components.

a) Expand primary care clinic space - In order to accommodate a new PCP, we will repurpose an existing building into a clinic facility. The building identified for this project is a combination of clinic and office space. Approximately one-third of the building houses an existing clinic practice. The remaining two-thirds is office space which will be repurposed/converted into a clinic facility.

Expand primary care clinic hours - This core component will not be included as the added space in the existing building will allow the additional provider to function during the existing business hours.

b) Expand primary care clinic staffing - Primary care clinic staffing will increase with the addition of the provider and hiring of necessary support staff. We expect to hire one receptionist, one nurse aide, one nurse, one file clerk and one insurance biller as support staff for the new PCP.

This project will be supported using the process milestones, P-1, expand existing primary care clinic space, and P-5, hire additional primary care provider. Each will be supported by the metrics documenting the hiring of a provider and renovation of

existing space to accommodate the provider. Improvement milestones will include I-11 patient satisfaction and I-12, increase primary care clinic volume of visits. New to our clinics will be the implementation of a patient satisfaction survey. This survey will ensure we are meeting the needs and expectations of patients, thus ensuring they continue seeking healthcare.

Unique community need identification numbers the project addresses:

- CN. 1. – Severe Primary Care Shortage
- CN 4. – High incidence of obesity, diabetes mellitus, and heart disease

How this project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Due to population growth and lack of PCP growth, our ability to meet the healthcare needs of our community is restricted. Adding a primary care provider to our existing clinic will significantly expand access to primary care, which is the key to improving healthcare outcomes and reducing the cost of healthcare. Monitoring patient satisfaction in our clinics will be a new endeavor used to evaluate and redesign as indicated, our provision of healthcare.

Related Category 3 Outcome Measures:

OD-1 Primary Care and Chronic Disease Management:
IT-1.11 Diabetes Care – BP Control (<140/80mmHg)

Reasons/rationale for selecting the outcome measures:

Many of the diagnosed diabetic patients in our community are low income or uninsured. Tracking and trending blood pressure control provides an overall and individualized opportunity to redesign the care we provide. It also gives the information needed to gauge the success of the care provided and denotes opportunities to provide individual patient education to those who fall out of the parameters of controlled BP. Accomplishing this in the primary care setting reduces financial strain on these individuals and the healthcare system. In DY3, we will develop a system for monitoring and reporting diabetic blood pressure as identified in Category 3 OD 1 – Primary Care and Chronic Disease Management, IT 1.1 – Diabetes Care – Blood Pressure Control. Blood pressure will be tested on each patient with a diagnosis of type 1 or 2 diabetes and recorded in the patients electronic health record (EHR). Reporting on diabetic patient blood pressure control will begin in DY 4.

Relationship to other Projects:

This project, 094121303.1.1.1.2, focuses on primary care and disease management. It relates to Category 2 projects, 2.3 Redesign Primary Care, 2.4 Redesign to Improve Patient Experience and 2.6 Evidence-based Health Promotion Programs. Related Category 4 measures include RD – 1 Potentially Preventable Admissions and RD – 4.1 Patient Satisfaction.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project is a basic foundation to support the overall goals of the waiver. There are two entry points to healthcare, the primary care provider and the emergency room. The emergency room is the most costly means to provide primary care. Access to primary care providers in a clinic setting assures patients receive high-quality and patient-centered care, in the most cost effective ways. Expanding primary care capacity provides the opportunity to develop a coordinated delivery system, focused on managing chronic diseases efficiently and effectively.	**5**
Addresses Community Need(s)	Access to primary care was the predominant healthcare need identified in both the local and regional community needs assessments. Expanding primary care access, therefore will significantly impact the health of the Medicaid and the uninsured population in Gaines County. In addition, having access to primary care will provide the opportunity to manage chronic disease and provide preventative healthcare.	**5**
Project Scope/Size	This project provides the opportunity to increase patient encounters and prevent "clinic" type ER visits. In our community, many patients rather than waiting a week or more for an appointment in the clinic seek primary care in the ER. Adding just one provider to our community will add 1,700 hours annually of available primary care. This could potentially translate into more than 4,500 patient encounters provided in the right setting and at the right time.	**4**
Project Investment	Recruiting a physician to a rural community is a significant investment. To successfully implement and sustain our project requires funds for legal counsel, equipment purchases, physician guarantee, and in our case, repurposing of existing space to accommodate a clinic.	**5**

094121303.1.1	Project Option. 1.1.2	1.1.2. a-c	Expand Primary Care Capacity, Expand Existing Primary Care Capacity
Gaines County Hospital District dba Memorial Hospital			**094121303**
Related Category 3 Outcome Measure(s): OD – 1	**094121303.3.1**	**IT-1.11**	**Diabetes Care – BP Control (<140/80 mmHg)**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-1] Expand Existing Primary Care Clinics Metric 1:[P – 1.1]: Additional Clinic Space Baseline/Goal: Re-purpose existing space into a clinic facility. Data Source: Documentation of expansion plan Estimated Milestone 1 Incentive Payment: $ 156,473 Milestone 2: [P-5]: Hire additional primary care providers and staff. Metric 1:[P – 5.1]: Documentation of increased number of providers and staff. Baseline/Goal: 4 providers/Goal of 5 Data Source: Documentation of contract/employing of provider and staff.	Milestone 3: [I-11]: Patient Satisfaction with Primary Care Services Metric 1:[I –11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Baseline/Goal: Baseline 0 . Goal to implement a patient satisfaction assessment tool. Data Source: Evidence based patient satisfaction assessment tool. Estimated Milestone 3 Incentive Payment: $ 181,372 *Milestone 4: [I-12] :* Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. *Metric 1: [I12.1]:* Documentation	Milestone 5: [I-11]: Patient Satisfaction with Primary Care Services Metric 1:[I –11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Baseline/Goal: . Baseline will be 0. Goal will be an average annual score of 4.3 on a 5.0 scale and survey completion of 50% of the increased clinic visits (1,500 increased clinic visits) thus 750 surveys completed. Data Source: Evidence based patient satisfaction assessment tool. Estimated Milestone 5 Incentive Payment: $ 183,247 *Milestone 6: [I-12] :* Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. *Metric 1: I12.1]:* Documentation of	Milestone 7: [I-11]: Patient Satisfaction with Primary Care Services Metric 1:[I –11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Baseline/Goal: Baseline will be 0. Goal will be an average annual score of 4.5 on a 5.0 scale and survey completion of 75% of the increased clinic visits (1,500 increased clinic visits) thus 1,125 surveys completed. Data Source: Evidence based patient satisfaction assessment tool. Estimated Milestone 7 Incentive Payment: $ 157,002 *Milestone 8: [I-12] :* Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. *Metric 1: I12.1]:* Documentation of

094121303.1.1	Project Option. 1.1.2	1.1.2. a-c	Expand Primary Care Capacity, Expand Existing Primary Care Capacity
Gaines County Hospital District dba Memorial Hospital			**094121303**
Related Category 3 Outcome Measure(s): OD – 1	**094121303.3.1**	**IT-1.11**	**Diabetes Care – BP Control (<140/80 mmHg)**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Estimated Milestone 2 Incentive Payment: $ 156,473	of increased number of visits. *Baseline/Goal:* Baseline 20,862. Demonstrate an increase of 2,000 patient visits over baseline. *Data Source:* Registry, EHR, claims or other performing provider source. Estimated Milestone 4 Incentive Payment: $ 181,373	increased number of visits. *Baseline/Goal:* . Baseline 20,682. Goal will be an increase of 3,500 patient visits over baseline. *Data Source:* Registry, EHR, claims or other performing provider source. Estimated Milestone 6 Incentive Payment: $ 183,247	increased number of visits. . *Baseline/Goal:* Demonstrate an increase of 4,500 patient visits over baseline. *Data Source:* Registry, EHR, claims or other performing provider source. Estimated Milestone 8 Incentive Payment: $ 157,002
DY 2 Estimated Milestone Bundle Amount: $ 312,946	DY 3 Estimated Milestone Bundle Amount: $ 362,745	DY4 Estimated Milestone Bundle Amount: $366,494	*DY5 Estimated Milestone Bundle Amount:* $314,003
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,356,188			

Project Option: 1.1.1 Expand Primary Care Capacity: Establish More Primary Care Clinics
Performing Provider/TPI: Moore County Hospital District (Memorial Hospital)/094129602
Unique Project ID: 094129602.1.1

Description of Facility: Moore County Hospital District ("MCHD") is a tax-supported, rural, sole-community provider, hospital district located in Dumas, Moore County, Texas. MCHD operates a 60-bed acute care hospital, 60-bed nursing home facility, Emergency Medical Service, Home Health, Hospice, and outpatient clinical ancillary services for Moore County. MCHD is designated as a Level IV Trauma Center. Moore County has a population of approximately 21,000.
Intervention: MCHD seeks to recruit a new primary care provider to Dumas, Moore County, Texas and establish his/her practice in a new clinic location.
Need for Project: Moore County is listed as a Health Professional Shortage Area and in need of additional primary care providers. As of December 2011, Moore County had five (5) hospital-affiliated primary care providers in our community. Given Moore County's population, this number of providers represents a shortage, leaving many patients without a medical home and current providers overloaded. In addition, MCHD anticipates the retirement of a local PCP within the next few years. Wait times for appointments are long and many residents are finding care either in out-of-town communities with approximate round-trip distances of 100 miles or seeking care in MCHD's emergency department.
Target Population: MCHD will employ the new provider. As such, the provider will see all payor classes in his/her practice (all patients regardless of their ability to pay). In DY2, MCHD estimates that the new clinic will provide 2,500 patient visits . Based on MCHD's payor mix, we estimate visits will be comprised : 700 Medicare; 675 Medicaid/Self-pay and Indigent; 1,050 Commercial and BC/BS; and 75 Other. In DY3, we estimate a total of 2,625 visits; in DY4, 2,750 visits; and, in DY5, 2,890 visits.
Category 1Expected Patient Benefit: The addition of a new primary care clinic will expand access to a community that currently has a shortage of primary care providers and provide a base for future growth through the recruitment of additional mid-level or physician providers. For the patients treated in this clinic, we will seek to control their blood pressure 094129602.3.1.7.

Category 3 outcomes: IT-1.7 Controlling High Blood Pressure. Our goal is to Increase the number of patients whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

Project Option: 1.1.1 Expand Primary Care Capacity: Establish More Primary Care Clinics
Performing Provider/TPI: Moore County Hospital District (Memorial Hospital)/094129602
Unique Project ID: 094129602.1.1

Project Description:

This project will seek to expand access to primary care in Moore County, Texas by establishing a new primary care clinic/practice in a new location. The target population will be the residents of the District, generally defined by the borders of Moore County. The CEO of Moore County Hospital District will be the primary point of contact for recruiting physicians to the community. The MCHD Executive Team will have responsibilities related to completing the process and establishing the recruit into a practice. The COO will be responsible for helping to credential the physician. HR will be responsible for sourcing and hiring office staff. The IT Director will be responsible for establishing a EHR for the clinic. The CFO will be responsible for establishing billing and collection processes. The recruiting process is as follows: (1) MCHD Physician Recruiting Committee approves recommendation for a search; (2) MCHD Board approves recommendation; (3) CEO contacts recruiters; (4) CEO waits for recruiters to call with candidates; (5) Recruiters call and submit CVs; (6) CEO conducts preliminary phone interviews; (7)steps 4-6 are repeated until a viable candidate is interviewed; (8) candidate is brought to Dumas for on-site interview; (9) if the candidate is deemed viable, negotiations begin; if not, repeat steps 4-8; (10) Successfully negotiated contracts are taken to MCHD Board for approval; (11) Efforts to relocate physician and open clinic begin.
This project will target primary care physicians (to recruit) in an effort to provide access to primary care for patients in our community. The project's target population is the residents of Moore County, Texas, population 21,000. We aim to provide access for all. By age, Moore County is: 28% age 0-14 years; 14% age 15-24; 13% age 25-34; 12% age 35-44; 13% age 45-54; 9% age 55-64; and , 10% age 65+. By gender, we are 49.5% female and 50.5% male. By ethnicity, we are 57% White, 36% Hispanic, 3% Black, and 9% All Other. The Hispanic population is the fastest growing segment of our community. Moore County falls below the State and National averages for Household Income: $52,171, $65,413, and $65,529, respectively. In 2012, MCHD's Payor Mix was: 28% Medicare, 14% Medicaid, 24% Commercial Insurers other than Blue Cross, 18% Blue Cross, 13% Self-pay, and 3% All Other. According to the US Bureau of Labor Statistics, Moore County has an unemployment rate of between 4.0 and 5.9 percent.). In DY2, MCHD estimates that the new clinic will provide 2,500 patient visits. Based on MCHD's payor mix, we estimate visits will be comprised of: 700 Medicare; 675 Medicaid/Self-pay and Indigent; 1,050 Commercial and BC/BS; and 75 Other. In DY3, we estimate a total of 2,625 visits; in DY4, 2,750 visits; and, in DY5, 2,890 visits.

As of December 2011, Moore County had five (5) hospital-affiliated primary care providers in our community. Given Moore County's population, this number of providers represents a shortage, leaving many patients without a medical home and current providers overloaded. In addition, MCHD anticipates the retirement of a local PCP within the next few years. Wait times for appointments are long and many residents are finding care either in out-of-town communities with approximate round-trip distances of 100 miles or seeking care

in MCHD's emergency department. Our five year expected outcome is to have opened a successful primary care practice in our community that continues to provide quality care to the residents of our area.
Region 12 is a predominantly rural area of the State and in great need of additional primary care providers. Obviously, this project seeks to attract those providers to the region. By bringing these providers to the area, we will create access for patient care.

Starting Point/Baseline:

Moore County has five full-time hospital-affiliated primary care providers (Family Practice and Internal Medicine, excluding OB/Gyn).

Rationale:

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.
Moore County, Texas has a primary service area population of 20,865, according to US Census data. Moore County is designated as a Health Professional Shortage Area (HPSA) in the State of Texas. Thompson-Reuters (Claritas) projects a physician demand for 21.12 primary care physicians (Family Practice, Internal Medicine, Pediatrics) using a population based formula. While this number of projected providers seems excessive, with only five (5) hospital-affiliated primary care providers, Moore County is clearly in a shortage situation. Thus, many patients are without a medical home and existing physician practices are overloaded. In addition, MCHD anticipates the retirement of a local PCP within the next few years. Wait times for appointments are long and many residents are finding care either in out-of-town communities with approximate round-trip distances of 100 miles or seeking care in MCHD's emergency department. The obvious solution is to recruit and retain new primary care providers to the community. It is MCHD's goal to recruit an additional hospital-affiliated primary care provider to our community and grow that practice over time. This relates to Community Need CN-1, “Severe Primary Care Provider Shortage.” Being as this project aims to establish a new clinic, it is clearly a new initiative. No other initiatives have or are in effect that are being funded by the U.S Department of Health and Human Services.

Related Category 3 Outcome Measures:

Moore County Hospital District chose **IT-1.7 Controlling High Blood Pressure** as the desired Category 3 Outcome Measure because it is a prevalent condition common to patients in Moore County. According to DSHS Vital Statistics, hypertension occurs in approximately 27.8-percent of the population. Region 1, which encompasses Moore County, is shown to be statistically consistent with the State average. In an article written by Dr. Henry White in the 2010 issue of Medicographia, "Published meta-analyses suggest that improved patient education will bring about a reduction in systolic blood pressure of up to 11 mm Hg; such a reduction in 10 million hypertensives would prevent about 150,000 cardiovascular events over 5 years." Extrapolating Dr. White's statistics for Moore County would prevent about 315 cardiovascular events over 5 years. Disease specific education best occurs when a patient has a regular, established relationship with a primary care provider. In 2011, Average Household Income in Moore County was $52,171. Moore County falls well below the State Average Household Income of $65,413 and the US Average Household Income of $67,529. Thus, given that Moore County Hospital District is obligated to serve the needs of all citizens, and given that the primary care position will be an employed position of the District, and given the prevalence of hypertension in the patient population, then it follows that the addition of a primary care provider to our community will enhance the ability to manage this disease process.

Relationship to Other Projects:

This project is related to other RHP projects in that many rural communities in the RHP are in need of new primary care providers. Most, if not all, are designated as HPSA's like Moore County. There is an indisputable positive correlation between access to primary care providers and community health. As a community seeking to increase access, Moore County is aligned with other RHP projects to enhance quality of life for our citizens. Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

- **Achieves Waiver Goals**: (5) In an area where there is a shortage of primary care providers, this project will attract a new provider and enhance access to care for all citizens of the area, including Medicaid beneficiaries. Likewise, by adding a primary care provider, care will be rendered in a clinic setting that is significantly less costly than accessing care in the Emergency Department. In doing so, the project will enable Moore County to meet Medicare's **Triple Aim** of high-quality, patient-centered care, in the most cost effective way.

- **Addresses Community Needs**: (5) As previously stated, local citizens are currently seeking primary care either in the Emergency Department or in communities with round-trip travel distances of approximately 100 miles. Market demand is not being met by local primary care supply.

- **Project Scope**: (4) In our small community, the addition of a new primary care provider would be "big". Obviously, the mere presence of this new position will allow residents to remain home for care.

- **Project Investment**: (4) The establishment of this primary care clinic will require significant investment (time and money) from human resources to staff the office, purchase of equipment and furnishings, legal contracting, and administrative supervision. The project will require countless hours to recruit a new provider and significant recruiting expense. This is a top strategic priority for the District, as determined by the Board.

094129602.1.1	*1.1.1*	*N/A*	Expand Primary Care Capacity: Establish More Primary Care Clinics	
Moore County Hospital District (Memorial Hospital)				*094129602*
Related Category 3 Outcome Measure(s):	*094129602.3.1*	*IT-1.7*	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-1 Establish additional/expand existing/relocate primary care clinics **Metric 1:** P-1.1 Number of additional clinics **Baseline/Goal:** Addition of one new clinic **Data Source:** New primary care schedule **Milestone 1 Estimated Incentive Payment $ 213,079**	**Milestone 2**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Demonstrate improvement (# of visits) of 5% over prior period, or 125 visits. **Data Source:** Registry **Milestone 2 Estimated Incentive Payment: $** 246,986	**Milestone 3**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Demonstrate improvement (# of visits) of 5% over prior period, or 131 visits. **Data Source:** Registry **Milestone 3 Estimated Incentive Payment: $** 249,540	**Milestone 4**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Demonstrate improvement (# of visits) of 5% over prior period, or 139 visits. **Data Source:** Registry **Milestone 4 Estimated Incentive Payment: $** 213,800
Year 2 Estimated Milestone Bundle Amount: $ 213,079	Year 3 Estimated Milestone Bundle Amount: $ 246,986	Year 4 Estimated Milestone Bundle Amount: $ 249,540	Year 5 Estimated Milestone Bundle Amount: $ 213,800
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $923,405			

Project Option: 1.9.2 Improve Access to Specialty Care
Performing Provider: Moore County Hospital District / Memorial Hospital/094129602
Project Identification Number: **094129602.1.3 –"PASS 3b"**
Project Components: 1.9.2.a-d

Provider: Moore County Hospital District ("MCHD") is a tax-supported, rural, sole-community provider, hospital district located in Dumas, Moore County, Texas. MCHD operates a 60-bed acute care hospital, 60-bed nursing home facility, Emergency Medical Service, Home Health, Hospice, and outpatient clinical ancillary services for Moore County. MCHD is designated as a Level IV Trauma Center. Moore County has a population of approximately 21,000.
Intervention: MCHD seeks to expand its weekend hospitalist program to full-time.
Need for the project: Increasingly, primary care providers are limiting their practices to outpatient settings. This trend has resulted in increased transfers from MCHD to hospitals in larger communities. This threatens the future stability of MCHD, inconveniences patients and families, and drives up healthcare costs. Additionally, because community-based primary care physicians seek outpatient-only practices, having to admit becomes a quality of life issue. The result is either physicians give-up their hospital privileges or they simply leave the community. Either way, access to care is negatively affected. Establishing a full-time hospitalist program is one viable solution.
Target Population: The hospitalist will see all payor classes in his/her practice (all patients regardless of their ability to pay). In DY2, MCHD estimates that the new hospitalist program will provide care to an incremental 588 admissions. Based on 2012 Inpatient admissions, 4 days per week of additional coverage, and MCHD's payor mix, MCHD estimates the following incremental inpatients would be seen by the proposed program: 163 Medicare; 158 Medicaid/Self-pay and Indigent; 245 Commercial and BC/BS; and 22 Other.
Category 1 Expected Patient Benefit: In DY3, 617 admissions; in DY4, 647 admissions; and, in DY5, 680 admissions. The expansion of MCHD's weekend hospitalist program to full-time will improve patient access to inpatient hospital care, reduce the average cost of hospitalization (compared to similar admission in tertiary care hospitals) and enhance the quality of life for existing community-based physicians; thus, ensuring continued access to primary care in the community. For patients seen in this practice, we will seek to improve the patient's satisfaction with physician communication, 094129602.3.2
Category 3 Outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores. Our goal is to improve scores by 5% over baseline year

Project Option: 1.9.2 Improve Access to Specialty Care
Performing Provider: Moore County Hospital District / Memorial Hospital/094129602
Project Identification Number: **094129602.1.3 – "PASS 3b"**
Project Components: 1.9.2.a-d

Project Description:

This project will seek to expand access to specialty care in Moore County, Texas by expanding the part-time hospitalist practice (currently weekends only, Friday-Monday) to full-time.

Moore County Hospital District began offering every-other weekend hospitalist services in June 2011. With the addition of a second physician to the schedule, the service went to every-weekend staffing in December 2011. The result of the service has been multifold. First, there has been a noticeable decline in transfers out of Moore County for locally appropriate admissions. This decline results in improved convenience for patients and families, and a cost reduction by virtue of saving the EMS transfer. Second, because a hospitalist is easily accessible to the facility, timeliness of care has been enhanced. Nurses on the acute care floors, in the nursery, and in MCHD's nursing home have all commented on the improved response time. Timeliness, in association with other factors, contributes to improved quality and perception of care. Third, it has served as an enhancement to the quality of life for local primary care physicians. Given the need to retain primary care services in our rural market, we see the hospitalist program as a key strategy for retaining primary care providers.

The project will be accomplished by a team effort between Moore County Hospital District and Amarillo Hospitalist Services, the contracted hospitalist group who provide services at MCHD. It will be MCHD's responsibility to provide the location and patient base for the program. AHS will recruit and supply the physicians. AHS will bill for services and MCHD will provide a net collection guarantee as a subsidy for the program.

This project will target all inpatients at Moore County Hospital District who are admitted to the hospitalist service. The project goal will be to increase the volume of patients treated by the expansion of the hospitalist service (as measured by an increase in the number of appropriate admissions to MCHD for patients admitted to the hospitalist service).

Starting Point/Baseline:

Moore County currently has no hospitalist coverage Monday through Thursday.

Rationale:

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed.

Moore County, Texas has a primary service area population of 20,865, according to US Census data. Moore County is designated as a Health Professional Shortage Area (HPSA) in the State of Texas. Increasingly, primary care providers are desiring to limit their practices to outpatient settings only. In large communities, this has progressively resulted in the development of hospitalist programs. Although lagging their larger-community peers, this trend is now reaching deep into rural communities. The result is that small hospitals are increasingly transferring appropriate admissions to larger communities which ultimately threatens the existence of the smaller hospital, inconveniences patients and families, and drives up healthcare costs. In particular, costs are driven higher due to the need to transport patients, and because recent studies have shown that care provided in small, rural hospitals cost less than equivalent services in large, tertiary care centers.

Additionally, because community-based primary care physicians increasingly no longer desire to cover hospital admissions, being forced to do so becomes a quality of life issue. The result is either physicians give-up their hospital privileges or they simply leave the community. Either way, access to care is affected. The provision of a full-time hospitalist service is the obvious solution. This relates to Community Need CN-5, "Need for Specialists." This project will expand an existing part-time hospitalist program to full-time. No other initiatives have or are in effect that are being funded by the U.S Department of Health and Human Services.

Our Milestones will be P-11.1, to establish the clinic, and Improvement targets will be I-23.1, to increase volumes.

Related Category 3 Outcome Measures:

Moore County Hospital District chose **OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction (2) how well doctors communicate** as the preferred Category 3 Outcome Measure because patient satisfaction has been clearly linked to improved patient compliance and outcomes. In an article published in the Fall 2002 edition of Ethnicity & Disease, author A.H. Fortin Department of Medicine at Yale University writes: "While clinicians face increasing time pressure in caring for patients, communication with the patient can suffer. Communication is especially important in caring for the increasingly culturally diverse patient population in the United States. Different values, beliefs, and attitudes about health, illness, and health care can affect illness outcomes. These are best understood through dialogue. Patient-centered communication skills are associated with improved health outcomes, improved patient and clinician satisfaction, and less risk of malpractice suits." Moore County Hospital District seeks to improve outcomes for all of our patient populations. We believe that improved patient communication with their physician during the hospitalization will positively impact outcomes.

Relationship to Other Projects:

This project is related to other RHP projects in that many rural communities in the RHP are in need of new specialty care providers. Most, if not all, are designated as HPSA's like Moore County. There is an indisputable positive correlation between access to specialty care providers and community health. As a community seeking to increase access, Moore County is aligned with other RHP projects to enhance quality of life for our citizens. This project is related to Unique Project Number 094129602.3.2

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative:

Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Increasingly, primary care physicians are reducing their practices to outpatient-only clinics. This change has created the specialty of hospitalists. Without hospitalists, access to inpatient care is jeopardized. Likewise, by expanding the hospitalist service, Medicare's **Triple Aim** of high-quality, patient-centered care, in the most cost effective way is achieved.	**4**
Addresses Community Need(s)	Local citizens need to have the ability to be admitted in their hometowns, when appropriate. Without hospitalists, this ability is placed at risk. Likewise, as admissions from primary care providers decline, the stability of the local hospital is harmed. Without a strong local hospital, access to care in rural communities for emergent and outpatient services is hindered.	**4**
Project Scope/Size	In our small community, the expansion of the hospitalist service to full-time would be "big". Obviously, by expanding this service to Monday through Thursday coverage, local residents will be allowed to remain home for care.	**3**
Project Investment	This service will require significant resources including recruitment expense and time. However, because this project will expand a part-time hospitalist service to full-time, infrastructure and process currently exists to ensure quality care is delivered.	**4**

094129602.1.3 – "PASS 3b"	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE	
Moore County Hospital District (Memorial Hospital)				*094129602*
Related Category 3 Outcome Measure(s):	*094129602.3.3*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-11: Launch/expand a specialty care clinic Metric 1 P-11.1: Establish/expand specialty care clinics (a) number of patient served by specialty care clinic. Baseline/Goal: Expansion of part-time hospitalist program to full-time. Data Source: Documentation of expanded specialty care clinic. Milestone 1 Estimated Incentive Payment *:* $ 236,231	**Milestone 2** I-23: Increase specialty care clinic volume and evidence improved access for patients seeking care. Metric 1 I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Demonstrate improvement over prior period Data Source: Registry Milestone 2 Estimated Incentive Payment: $ 262,129		**Milestone 3** I-23: Increase specialty care clinic volume and evidence improved access for patients seeking care. Metric 1 I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Demonstrate improvement over prior period Data Source: Registry Milestone 3 Estimated Incentive Payment: $ 252,028	**Milestone 4** I-23: Increase specialty care clinic volume and evidence improved access for patients seeking care. Metric 1 I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Demonstrate improvement over prior period Data Source: Registry Milestone 4 Estimated Incentive Payment: $ 207,603
Year 2 Estimated Milestone Bundle Amount: $236,231	Year 3 Estimated Milestone Bundle Amount: $262,129		Year 4 Estimated Milestone Bundle Amount: $252,028	Year 5 Estimated Milestone Bundle Amount: $207,603
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 957,991				

Project Option: 1.1.1 Establish more Primary Care Clinics
Performing Provider Name/TPI: Muleshoe Area Medical Center/ 130877708
Unique Project ID: 130877708.1.1

Provider: Muleshoe Area Medical Center is a 25 bed Critical Access hospital in Muleshoe, Texas, serving a town of approximately 5,200 people and 7,347 in Bailey County. We also receive patients from other surrounding counties such as Parmer and Lamb in Texas along with Curry and Roosevelt in New Mexico.

Intervention: This project will add an additional clinic/practice in an existing space with a primary care physician in order to provide better, more efficient, more convenient primary care for our community and surrounding areas.

Need for the project: Bailey County is listed as a Health Professional Shortage Area and in need of additional primary care providers. As of September 2012, Bailey County had six (four full-time and 2 very part-time) hospital-affiliated primary care providers in our community. This number of providers represents a shortage, leaving many patients without a medical home and current providers overloaded. In addition, MAMC anticipates the retirement of a local PCP within the next few years. Many residents are finding care either in out-of-town communities with approximate round-trip distances of 100 to 200 miles or seeking care in MAMC's emergency department.

Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting periods have significant impact on patient and provider satisfaction and quality of care, and discourage people from using healthcare proactively. Low income people are also less likely to have the availability of resources to travel, therefore, if they are not able to get an appointment locally, they will probably be forced to ignore the care they need.
In addition, due to low or negative operating margins of public hospitals, we are relatively disadvantaged in physician recruiting.

Expected outcome is increasing the availability of primary care providers in Muleshoe in order to provide better, more efficient, more convenient primary care for our community and surrounding areas.

Target Population: Our target population is the residents of Muleshoe approximately 5,200 people and 7,347 in Bailey County with many more coming from surrounding counties. With 19.2% of the population in Bailey County under Federal Poverty Guidlines, we feel as though all of our population, including the Medicaid and indigent populations, will benefit from this project by providing local healthcare when people are not able to travel. We assume the current MAMC payer mix of 33% Medicare, 15% Medicaid, 42% Insurance, and 10% private pay.

Category 1 expected patient benefits: The addition of a new primary care clinic will expand access to a community that currently has a shortage of primary care providers and provide a base for future growth. We recognize that many patient visits will simply be transferred from one clinic to the new one. However, the project milestones and metrics are based on an overall increase in the volume of patient visits. This project seeks to provide 35 more visits per month (420 per year) in DY4, 50 more visits per month (600 per year) in DY5. With the addition of a primary care provider, more patients will have a stable medical home and continuity of care will increase the health of our community.

Category 3 outcomes: IT-6.1 Patient Satisfaction. The Category 3 outcome is directly related to this Category 1 project in the respect that the outcome for this project will not only allow more individual access to basic health care but will also accentuate the value of that care by addressing complete patient wellness. The Patient Satisfaction Survey addresses issues of timely care, appointments, information and physician/practitioner care. The increase of one additional PCP will reduce the workload of the current PCPs and allow for more personal, integrated care for the individual patient.

Project Option: 1.1.1 Establish more Primary Care Clinics
Performing Provider Name/TPI: Muleshoe Area Medical Center/ 130877708
Unique Project ID: 130877708.1.1

Project description:

Our goal is to increase MAMC's ability to treat more patients in the primary care capacity in order to better accommodate the needs of our patient population. This project will seek to expand access to primary care in Bailey County, Texas, by establishing a new primary care clinic/practice. The target population will be the residents of Bailey County.

As of September 2012, Bailey County had six (4 full-time and 2 very part-time) hospital-affiliated primary care providers in our community. This number of providers represents a serious shortage, leaving many patients without a medical home and current providers overloaded. In addition, MAMC anticipates the retirement of a local PCP within the next few years. Many residents are finding care either in out-of-town communities with approximate round-trip distances of 100-200 miles or seeking care in MAMC's emergency department.

With regular primary care, chronic conditions are less likely to become acute episodes, reducing the risk for disability and premature death. Reducing long waiting periods will have significant impact on patient and provider satisfaction and quality of care, and encourage people to use healthcare proactively. Low income people who may not have the availability of resources to travel will have greater access to the health care that they need.

Our expected outcome is increasing the availability of primary care providers in MAMC's clinics in order to provide better, more efficient, more convenient primary care for our community and surrounding areas. By expanding primary care clinic staffing, we are better able to address the needs of our community. Our five year expected outcome is to be able to accommodate the needs of the patient population so they are better able to receive the right care at the right time in the right setting and provide patients with more preventative and proactive care regardless of their ability to pay.
Region 12 regional goals are to address as many of the community needs in the community needs assessment as possible. We are focusing on the most critical need established by our community. In addressing this need, we are partnering with the region in meeting the needs of our community.

Starting Point/Baseline: As of September 2012, MAMC had six Primary Care Providers (four full-time and two very part-time) who conducted 1,048 visits during that month or 12,473 annually. Currently MAMC's Emergency Department is frequently being staffed by temporary PCPs.

Rationale: We have chosen this project due to the shortage of primary care providers our area. In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. Many patients are without a medical home and existing physician practices are overloaded. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting.

The obvious solution is to recruit and retain new primary care providers to the community. It is MAMC's goal to recruit an additional hospital-affiliated primary care provider to our community and grow that practice over time. This relates to Community Need CN-1, "Severe Primary Care Provider Shortage." By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services. There are currently two clinics associated with Muleshoe Area Medical Center. The addition of a new clinic will be an expansion of the services currently provided.

Project components are: 1) Expand primary care clinic space - we have clinic space available and will establish new clinic/practice in this space. 2) Expand primary care clinic staffing – this will be fulfilled by recruiting a primary care physician and staff to provide care for patients in our community. Milestones for this project will be (I-12) to increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Our metric will be (I-12.1.a) Documentation of increased number of visits and total number of visits for reporting period. Again, our project focuses on the most critical need determined by our community needs assessment and our RHP 12 Needs Assessment Summary.

Unique community need identification numbers the project addresses:

- CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.3 - Poor insurance support or uninsured

Relationship to other Projects: This project is related to other RHP projects in that many rural communities in the RHP are in need of new primary care providers. Most, if not all, are designated as HPSA's like Bailey County. There is an indisputable positive correlation between access to primary care providers and community health. As a community seeking to increase access, Bailey County is aligned with other RHP projects to enhance quality of life for our citizens.

Relationship to other Performing Provider Projects and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In

addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	In Bailey County, the low income, uninsured, and minority populations are higher than the state average. Those individuals often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute conditions putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long wait times have significant negative impact on patient and provider satisfaction and quality of care, and discourage people from using healthcare proactively. Low income people are less likely to have the availability of resources to travel, therefore, if they are not able to get an appointment locally, they will probably be forced to ignore the care they need. By having an additional provider in the local clinic, we will be able to provide better, more efficient, more convenient, primary care for our community and surrounding areas.	**5**
Addresses Community Need(s)	This project meets the highest community need identified (CN.1), which addresses the shortage of primary care providers. By providing another PCP, we will have more physicians to see the patients that have poor insurance support or are uninsured (CN.3). The need for more physicians is continually increasing due to the increase in population and the increase in health issues in rural areas.	**5**
Project Scope/Size	We expect to reach all patients in our community regardless of their ability to pay. We expect to increase our patient encounters and provide service to as many people as possible in our community so they do not have to travel. We expect patients will be able to take care of their needs locally where they can receive the right care in the right setting at the right time.	**5**

Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have enough physicians to ensure our patients are seen in an appropriate setting when they need care. Our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all the staff needed and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined as the project is implemented and as needs arise.	**5**

130877708.1.1	1.1.1	N/A	Establish additional Primary Care Clinic and Recruit Primary Care
Muleshoe Area Medical Center		130877708	
Related Category 3 Outcome Measure(s):	**130877708.3.2**	**IT-6.1**	**Patient Satisfaction Survey**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-1.1 Develop a plan for establishing one additional clinic **Metric 1:** P-1.1 Documentation of detailed expansion plans for opening **Baseline:** Two clinics **Data Source:** Clinic registries **Milestone 1 Estimated Incentive Payment $** **Milestone 2:** P-5.1 Begin recruiting efforts **Metric 1:** P-5.1 Documentation of detailed plans for staffing new clinic **Baseline:** 6 PCPs Two clinics **Data Source:** Clinic registries **Milestone 1 Estimated Incentive Payment $42,159**	**Milestone 3**: P-1.1 Establish one additional clinic and recruit one PCP **Metric 1:** P-1.1 Clinic Schedule **Goal:** Total 3 clinics **Data Source:** Clinic registries **Milestone 3 Estimated Incentive Payment: $** **Milestone 4**: P-5.1 Contract with one additional PCP **Metric 1:** P-5.1 Documentation of contract with new PCP **Goal:** Total 7 PCPs **Data Source:** Board approved contract **Milestone 4 Estimated Incentive Payment: $ 48,867**	**Milestone 5**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** I-12.1 Increase total patient visits by 420 over baseline **Goal:** Total of 12,893 visits **Data Source:** Clinic Registries **Milestone 5 Estimated Incentive Payment: $ 49,372**	**Milestone 6**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **Metric 1:** I-12.1 Increase total patient visits by 600 over baseline **Baseline/Goal:** Total of 13,073 visits **Data Source:** Clinic Registries **Milestone 6 Estimated Incentive Payment: $ 42,301**
DY 2 Estimated Milestone Bundle Amount: $ 42,159	DY 3 Estimated Milestone Bundle Amount: $ 48,867	DY4 Estimated Milestone Bundle Amount: $ 49,372	DY5 Estimated Milestone Bundle Amount: $ 42,301
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $182,699			

Project Option: **1.1.2** Expand Existing Primary Care Capacity
Performing Provider/ TPI: Ochiltree Hospital District / 112704504
Unique Project ID: 112704504.1.1
Project Components: 1.1.2.a-c

Provider: Ochiltree Hospital District (OHD) is located in Perryton, TX, estimated population 9,065 in the northernmost county seat located in Ochiltree County, Texas estimated population 10,530. OHD also serves the surrounding counties: Lipscomb County, Texas; Hansford County, Texas; Hemphill County, Texas; Texas County, Oklahoma and Beaver County, Oklahoma. OHD operates one primary care clinic named the Perryton Health Center: providing pediatrics, family practice and obstetrics in eight exam rooms. Ochiltree County estimated population is 18% female of childbearing years and the clinic currently serves 10,341 patients and of those 2,448 were Medicaid and 593 were Medicare. They also an estimated 175 obstetrics and only 52.3% receive prenatal care in the first trimester.
Intervention (s): OHD will expand the clinic space by building a 1 new clinic, the current clinic will increase its primary care service hours by remaining open for longer hours in the evening, and finally OHD will increase clinic staffing by hiring a new FP/OB over the next five years. We plan to enhance patient access to primary care services by reducing days to third next-available appointment.
Need for the project: At this time the clinic does not have the capacity to see all patients needing appointments, and wait time for the next available date for specialty appointments is 30 days and 250 mile round trip travel. Currently, the clinic is open during the weekdays and weekends and has evening hours only on weekends. Although the clinic has same-day appointment slots, the supply is limited. Approximately 15% who call wanting a same-day appointment receive an appointment that day. Therefore, patients call the appointment line as early as possible to receive these appointments, creating a backlog in the number of calls that can be answered, and long wait times for a scheduler via phone.
As we prepare for the increase of individuals insured through health reform in 2014, many patients will be placed in managed care environments that require them to be assigned to a primary care provider. OHD will need to increase its capacity to be able to see these patients in a timely manner in order to create more continuity of care, a positive patient experience and become the provider of choice for our community and surrounding communities.
Target population: The target population is our patients that need access to providers and to providers after hours. Our Medicaid eligible or indigent patients may only have access to transportation after five o'clock when family or friends get off work to give them a ride. Approximately 50% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the clinics expanded primary care. Our target population is 12,000 to 13,000 due to we are the only hospital in the area that does deliveries.
Category 1 or 2 expected patient benefits: The project seeks to provide access to providers in a clinic setting over ER visits.
Category 3 outcomes: IT-6.1 Our goal is to increase our patient satisfaction by 5% by DY5 after we have set up CG-CAQH and have established our baseline rates in DY3.

Project Option: **1.1.2** Expand Existing Primary Care Capacity
Performing Provider/ TPI: Ochiltree Hospital District / 112704504
Unique Project ID: 112704504.1.1

Project Components: **1.1.2.a-c**
Expand existing primary care capacity
Required core project components:

a) Expand primary care clinic space - by building 1 new clinic by the end of DY3.
b) Expand primary care clinic hours - by at least 8 hours per week in our current clinic by the end of DY3.
c) Expand primary care clinic staffing - by hiring a new FP/OB by the end of DY3

Project Description:

Ochiltree Hospital District (OHD) is located in Perryton, TX, estimated population 9,065 in the northernmost county seat located in Ochiltree County, Texas estimated population 10,530. OHD also serves the surrounding counties: Lipscomb County, Texas; Hansford County, Texas; Hemphill County, Texas; Texas County, Oklahoma and Beaver County, Oklahoma. OHD operates one primary care clinic named the Perryton Health Center: providing pediatrics, family practice and obstetrics. Ochiltree County estimated population is 18% female of childbearing years and the clinic currently serves 10,341 patients and of those 2,448 were Medicaid and 593 were Medicare. They also an estimated 175 obstetrics and only 52.3% receive prenatal care in the first trimester.

At this time the clinic does not have the capacity to see all patients needing appointments, and wait time for the next available date for specialty appointments is 30 days and 250 mile round trip travel. Currently, the clinic is open during the weekdays and weekends and has evening hours only on weekends. Although the clinic has same-day appointment slots, the supply is limited. Approximately 15% who call wanting a same-day appointment receive an appointment that day. Therefore, patients call the appointment line as early as possible to receive these appointments, creating a backlog in the number of calls that can be answered, and long wait times for a scheduler via phone.

As we prepare for the increase of individuals insured through health reform in 2014, many patients will be placed in managed care environments that require them to be assigned to a primary care provider. OHD will need to increase its capacity to be able to see these patients in a timely manner in order to create more continuity of care, a positive patient experience and become the provider of choice for our community and surrounding communities.

Goal:

Per the Texas 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, OHD's Category 1 includes infrastructure development, including investment in people, places, processes and technology. This plan describes how the Category 1 infrastructure development will expand access to care with strong emphasis on building coordinated systems that promote preventive and primary care.

The goal of this project is to expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Expanding primary care capacity will lead to improved quality and lower costs, as access to primary care has been shown to reduce more costly avoidable visits to the emergency department and the hospital. We plan to improve primary care capacity by doing the following:

- Increase square footage to accommodate the increase in providers.
- Increase clinic hours to evenings.
- Triage patient appointments to ensure that same day appointment slots are available for the most urgent patients.
- Provide urgent appointments within 24 hours of request. Provide non urgent appointments within 3 calendar days of request.
- Increase the number of local primary care providers.
- Increase the number of local primary care providers practicing obstetrics.
- Increase the number of local primary care encounters.
- Retain the number of existing primary care providers (with exception of known retirements).
- Improve patient outcomes and population health.

Challenges/issues:

Increasing the number of providers has proven to be challenging due to the remote location of this community. Recruiting from within our local community by covering half of the Outstanding Rural Scholarship Program and on completion of the program, they will commit to working in the community year for year of the assistance provided will help to fill the provider needs of our community.

5-year Expected Outcome for Performing Provider and Patients:

- Urgent appointments will be reduced to within 24 hours, as a result of expanding primary care clinic hours and providing appropriate urgent appointments to patients. The third next available appointment will be reduced to 5 calendar days, as a result of expanding primary care clinic hours and providing appropriate urgent appointments to patients. We will be measuring third next available date which has been cited by the Institute for Healthcare Improvement as a more sensitive reflection of appointment availability compared to next available date.
- Improved local primary care and obstetrics services and improved distribution of primary care and obstetrics workload.
- A healthier community.

Relationship to Regional Goals:

Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Starting Point/Baseline Data:

- Expand primary care clinic space – OHD has 1 primary clinic and was renovated in 2009.
- Expanding primary care clinic hours – to be determined within the year.
  - Expand primary care clinic staffing – 5 local primary care physicians (1 expected to retire) and 1.5 local nurse practitioners (1 expected to retire). 1 to 2 expected to drop obstetric services, leaving only 1 or 2 physicians to provide OB care to patients in the six (6) counties listed in the Narrative/Description Section above.

Rationale:

The project option chosen by OHD is very critical to its community and its ability to provide services need by the community. In project 1.1.2, OHD will expand the clinic space by building a new clinic, it will increase its primary care service hours by remaining open for longer hours in the evening, and finally OHD will increase clinic staffing by hiring a new FP/OB over the next five years. In doing this, OHD will show process milestones of P-1, Establish additional/Expand existing/relocate primary care clinic, P-4, Expand the hours of the primary clinic where they are currently serving patients from 9-5 M-F and weekends and has evening hours only on weekends, and P-5, Train/Hire additional primary care providers and staff thru hiring a FP/OB. OHD will have Improvement Milestones of I-12, Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. In doing all of this, OHD will be better able to serve its population and help to ensure patients seen timely and their needs addressed.

Related Category 3 Outcome Measures:

OD – 6 Patient Satisfaction

IT-6.1 – Percent improvement over baseline of patient satisfaction scores.

Unique RHP outcome identification number(s): 112704504.3.1

Outcome Measure Description:

IT-6.1 – Percent improvement over baseline of patient satisfaction scores.

1. How well their doctors communicate.
   a. Numerator: Percent improvement in targeted patient satisfaction domain
   b. Data Source: Patient survey
   c. Denominator: Number of patients who were administered the survey

Reasons/rationale for selecting the outcome measures:

Rationale/Evidence: The intent of the CG-CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Relationship to other Projects: None

Relationship to other performing provider projects and plan for learning collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)

Achieves Waiver Goals	This project will ensure patients have access to primary care when they need it. Having access to primary care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to primary Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED.	5
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	3
Project Scope/Size	While there is opportunity to increase the total number of visits, the population of Ochiltree County is fairly small thus reducing the potential for significant savings as a result of this project.	3
Project Investment	The investment required for this project is high. The cost of adding exam space and recruiting additional staff and providers if very significant. It will take several years to achieve all the goals outlined in this project.	3

UNIQUE IDENTIFIER: 112704504.1.1	RHP PP REFERENCE NUMBER: 1.1.2	PROJECT COMPONENTS: 1.1.2 (A-C)	PROJECT TITLE: Expand Existing Primary Care Capacity	
Performing Provider Name: Ochiltree Hospital District				TPI - 112705404
Related Category 3 Outcome Measure(s):	112704504.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1: [P-4.1] Increase number of hours at primary care clinic over baseline. Goal: Increase hours at primary care clinic by at least 2 hours per week. Data Source: Clinic documentation of new hours. **Milestone 1 Estimated Incentive Payment $ 219,814**	**Milestone 2** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1: [P-4.1] Increase number of hours at primary care clinic over baseline. Goal: Increase hours at primary care clinic by at least 8 hours per week. Data Source: Clinic documentation of new hours. **Milestone 2 Estimated Incentive Payment $ 396 254,793**		**Improvement Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-12.1] Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase number of visits by 5% over prior year. Data Source: Patient/treatment Logs. **Milestone 4 Estimated Incentive Payment $ 85,808** **Milestone 5:** [P-5] Train/hire additional primary care providers and staff/or increase the number of primary care clinics for existing providers. Metric 1: [P-5.1] Documentation of increased number of providers and staff and/or clinic sites Rational: Additional staff members and providers may be	**Milestone 7 Estimated Incentive Payment $ 110,278** **Milestone 8**: [P- 4] [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1: [P-4.1] Increase number of hours at primary care clinic over baseline. Goal: Increase hours at primary care clinic by at least 2 hours per week. Data Source: Clinic documentation of new hours. **Milestone 8 Estimated Incentive Payment $ $ 110,278**

UNIQUE IDENTIFIER: 112704504.1.1	RHP PP REFERENCE NUMBER: 1.1.2	PROJECT COMPONENTS: 1.1.2 (A-C)	PROJECT TITLE: Expand Existing Primary Care Capacity	
Performing Provider Name: Ochiltree Hospital District				TPI - 112705404
Related Category 3 Outcome Measure(s):	112704504.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			necessary to increase capacity to deliver care. Goal: **Milestone 5 Estimated Incentive Payment $ 85,809** **Milestone 6 Estimated Incentive Payment $ 85,809**	
Year 2 Estimated Milestone Bundle Amount: $219,814	Year 3 Estimated Milestone Bundle Amount: $254,793		Year 4 Estimated Milestone Bundle Amount: $257,426	Year 5 Estimated Milestone Bundle Amount: $220,557
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $952,590				

Project Option: 1.1.2 Expand Primary Care Capacity, Expanding existing primary care capacity

Performing Provider: Pampa Regional Medical Center/178848102

Unique Project ID: 178848102.1.1

Project Components: 1.1.2.a-c

Provider: Pampa Regional Medical Center is a 112 bed hospital in the town of Pampa serving a 60 square mile area and a service population of approximately 22,879.

Interventions: This project will expand primary care clinic space, expand primary care clinic hours and expand primary care clinics and provide more primary care providers to the area. The project will allow for families to align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services.

Need for the project: PRMC has 1 primary care provider that was recruited and started seeing patients in September and has been leasing space from another facility. Due to the lack of primary care providers and limited clinical hours people of Gray county seek medical treatment in the emergency room causing adding financial burden due to misutilization of resources or have to commute to Amarillo or at the worse neglect their need for medical treatment.

Target population: The target population is the people of Gray County without a primary care provider that have chronic medical conditions and those who occasional acute care needs. Approximately 43.4% of patients served at PRMC are either Medicaid or indigent, so we expect they will benefit from the extended hours and the continuity of a primary care provider.

Category 1 or 2 expected patient benefits: The project seeks to align patient with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services. Also this project would decrease the rate of readmissions due to readmissions occur to lack of follow up care after hospitalization.

Category 3 outcomes: Our goal is more providers would lend to the aggressive treatment of high blood pressure, allow for patients to receive education on disease process and encourage compliance. There is a 9.5% readmission rate for circulatory problems which is a 7.7 million dollar burden to Medicaid our goal for DY5 is 5%.

Project Option: 1.1.2 Expand Primary Care Capacity, Expanding existing primary care capacity

Performing Provider: Pampa Regional Medical Center/178848102

Unique Project ID: 178848102.1.1

Project Components: 1.1.2.a-c

Project Description: The project goal for Pampa Regional Medical Center is to expand primary care clinic space, expand primary care clinic hours and expand primary care clinic. Gray County is recognized as a Health Provider Shortage Area (HPSA), and currently our challenges and issues are that currently we are not staffed with primary care staff to meet the needs of our community. Primary care physicians are needed to serve the isolated area and surrounding communities. Our facility operates on the very minimal number of providers for our community so recruitment and retention are the backbone of our structure. Persons in need of care cannot get cost effective care without having to access the Emergency Department or travel to other cities. However to meet the staffing needs we also have to expand the care clinic space 600 square feet per new provider and 3 full time employee's and expand the clinic staffing hours. Our project would address the challenges and issues we are planning to recruit at least 2 primary care providers and 3 mid-levels at Pampa Regional Medical Center Hospital. PRMC will also expand the primary clinic space by remodeling an existing building to provide office/clinic space also we will expand the hours of service. Improving and expanding local primary care services will enhance a healthier community. Physician recruiting and retaining the PCP in our communities is vital. By DY 5, PRMC will have 2 PCP's, 3 mid-levels expanded clinical offices and service hours. This project will meet regional goals by access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Starting Point/Baseline: As of October 2010 PRMC has 1 primary care provider that was recruited and started seeing patients in the month of September, and due to lack of clinic space we are currently leasing an office space in a building not owned by PRMC. June 1, 2012 PRMC acquired 3 midlevel providers that have been seeing an average of 32 patients a day. No patient has been turned away due to lack of payer source.

Rationale The reasons for selecting the project option is PRMC needs access to additional PCP's in order to decrease the burden that is placed on Emergency Room departments seeing patients with acute or chronic health issues instead of emergent medical needs. Also by increasing PCP's and accepting all patients no matter what payer source they have or lack of payer source will improve access to primary and preventive care it the home community of the patients. Project components are expanding primary care clinic spaces, expanding primary care clinic hours and expanding primary care clinic staffing. Our project would address the challenges and issues we are planning to recruit at least 2 primary care providers and 3 mid-levels at Pampa Regional Medical Center Hospital. PRMC will also expand the primary clinic space by remodeling an existing building to provide office/clinic space also we will expand the hours of service. Improving and

expanding local primary care services will enhance a healthier community. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services which significantly enhances the existing initiative. Also this project would decrease the rate of readmissions due to the fact readmissions occur to lack of follow up care after hospitalization and by increasing primary care providers it would offer a more convenient way for the community to receive follow up care.

CN1 – Access to Primary Care

Milestones and metrics are relevant to the current population of 22,879 for Gray County alone with only 16 local primary care physicians.

Related Category 3 Outcome Measure(s): OD-1-Primary care and Chronic Disease Management IT-1.7 controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018). The reason/rational for selecting the outcome was that by providing more primary care providers would lend to the aggressive treatment of high blood pressure. More providers and extended hours would make it convenient for patients to have regular checkups and treatment when needed.
There is a 9.5% readmission rate for circulatory problems which is a 7.7 million dollar burden to Medicaid
By increasing primary care providers, increasing service hours and accepting patients no matter what their payer source is will promote patient compliance, allow for patients to receive education on the disease process and encourage compliance.

Relationship to other Projects: This project will help us accomplish our CAT 3 –IT-1.7 Controlling High Blood Pressure 178848102.3.1

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project will ensure patients have access to primary care when they need it. Having access to primary care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to primary Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED.	**5**
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	**5**
Project Scope/Size	While there is opportunity to increase the total number of visits, the population of Gray County is fairly small thus reducing the potential for significant savings as a result of this project.	**5**
Project Investment	The investment required for this project is high. The cost of adding exam space and recruiting additional staff and providers if very significant. It will take several years to achieve all the goals outlined in this project.	**5**
Plans for Intervention	2 additional providers will be added to the clinic along with 3 full time employees per provider. We will use outside recruiting companies as well as aggressively seeking out potential physicians. Extend clinic hours of operation to 6pm on Fridays. Contract with outside construction companies, electrical company and plumbing companies to expand and renovate current building to provide for 600 square feet of office space per provider. PRMC will purchase 6 additional licenses for E-Clinical EMR.	**5**

178848102.1.1	1.1.2	1.1.2.a-c	Expand Primary Care Capacity, Expand existing primary care capacity
Prime Healthcare dba Pampa Regional Medical Center		**178848102**	
Related Category 3 Outcome Measure(s):	**178848102.3.1**	**IT-1.7**	**Controlling high blood pressure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-1 Establish additional/expand existing/relocate primary care clinics. **Metric 1:P-1.1** 2 additional primary care providers with 3 FTE per provider in expanded clinical space of at least 600 sq ft per provider. Expanded clinical hours to 6pm on Fridays **Goal:** Documentation of detailed expansion plans **Data Source:** New primary care schedule or their Performing Provider document or other plans as designated by Performing Provider. **Estimated Milestone 1 Incentive Payment: 367,997** **Milestone 2: P-5** Train/hire additional 2 primary care providers and 3 staff and/or increase the number of primary care clinics for existing providers.	**Milestone 3: I-11** Patient satisfaction with primary care services **Metric 1: I-11-1** Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. **Goal:** Demonstrate 10% improvement over prior reporting period. **Data Source:** CG-CAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. **Estimated Milestone 3 Incentive Payment: $802,930** $	**Milestone 4: P-1** Establish additional/expand existing/relocate primary care clinics. **Metric 1:P-1.1** Number of additional clinics or expanded hours or space **Goal:** Documentation of detailed expansion plans **Data Source:** New primary care schedule or there Performing Provider document or other plans as designated by Performing Provider. **Estimated Milestone 4 Incentive Payment:** **$ 805,264**	**Milestone 5: I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1: I-12-1** Documentation of increased number of visits. **Goal:** Demonstrate 10% improvement over prior reporting period. **Data Source:** Registry, EHR, claims or other Performing Provider source **Estimated Milestone 5 Incentive Payment:** **$ 665,218**

178848102.1.1	1.1.2	1.1.2.a-c	Expand Primary Care Capacity, Expand existing primary care capacity
Prime Healthcare dba Pampa Regional Medical Center		**178848102**	
Related Category 3 Outcome Measure(s):	**178848102.3.1**	**IT-1.7**	**Controlling high blood pressure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Metric 1: P-5.1. Documentation of increased number of providers and staff and/or clinic sites. **Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation **Baseline:** As of Sep 2012 there is one primary care provider and 3 mid-levels. Currently PRMC is leasing office space. **Estimated Milestone 2 Incentive Payment:** $ 367,997			
***DY 2 Estimated Milestone Bundle Amount**: 735,994*	**DY 3 Estimated Milestone Bundle Amount:** $ 802,930	**DY4 Estimated Milestone Bundle Amount:** $ 805,264	***DY5 Estimated Milestone Bundle Amount:** $ 665,218*
***TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 3,009,406*			

Project Title: 1.1.1 Establish More Primary Care Clinics
Performing Provider: Physician Network Services/079877902
RHP Unique Identification Number: 079877902.1.1 – **Pass 2**
Project Option: 1.1.1 Establish more primary care clinics

- **Provider:** UMC Physician Network Services (PNS) is a physician practice management group formed by UMC in 1996. Since its inception, it has grown to over 100 providers representing all primary care specialties. Our support staff consists of more than 450 experienced health care employees. We have approximately 35 practice sites located throughout Lubbock and the surrounding area. Combined, these practices conduct nearly 400,000 patient visits annually.
- **Interventions(s):** The project will expand the availability of primary care in our community through the addition of two new primary care clinics. These clinics will have the ability to provide care to the South Plains area including the Medicaid and underserved population of the areas in which their clinic is established. According to the Texas Department of Rural Affairs, 90% of the counties within a 150 mile radius of Lubbock are considered Whole County medically underserved areas or Partial County medically underserved areas. Specifically, the majority of the census tracts located in the area of the second clinic are considered medically underserved areas.
- **Need for the Project:** The number one identified community need in our region is access to primary care. As per a gap analysis performed in our community, there is an extreme shortfall in family practice and internal medicine providers. A recent report on Advisory.com shows that Texas is ranked 5th among states as the lowest physician to 100,000 population ratio.
- **Target Population:** The first clinic to be established will be in the South Plains Mall. The annual full capacity of this clinic is expected to be 12,000 visits. The South Plains Mall is home to nearly 2,500 employees and has an annual rate of ten million patrons that visit from a large area that encompasses most of west Texas and eastern New Mexico (150 mile radius). We anticipate that at least 25% of the patient population will be Medicaid or self-insured.
- The second clinic to be established will be located in Lubbock on the Interstate 27 corridor. The annual full capacity of this clinic is expected to be 15,000 visits. Although the clinic will be open to all patients, we believe the specific target area would be the residents of the city of Lubbock that live in the following zip codes: 79401, 79403, 79404, 79411, and 79412. According to City-data.com, households within these zip codes with income levels below the poverty line are 50%, 24.2%, 28.9%, 36.4%, and 27.1% respectively. We anticipate at least 40% of the patient population will be Medicaid or self-insured.
- **Category 1 Expected Patient Benefits:** In DY3 we anticipate the patient benefit to be 4,000 visits, In DY4 we anticipate the patient benefit to be 10,000 visits from our 2 clinics (42% or 5,000 from first clinic and 33% or 5,000 from the second one), In DY5 we anticipate the patient benefit to 12,500 primary care visits (6,250 or 52% from first clinic and 6,250 or 42% from second clinic)
- **Category 3 Outcomes:** Our goal is to reduce the number of patients with a blood pressure range that is considered to be at-risk (>140/90mm Hg). Once baselines are determined, improvement percentages can be determined.

Project Title: 1.1.1 Establish More Primary Care Clinics
Performing Provider: Physician Network Services/079877902
RHP Unique Identification Number: 079877902.1.1 **– Pass 2**
Project Option: 1.1.1 Establish more primary care clinics

Project Description:

UMC Physician Network Services proposes to expand the capacity of primary care to better accommodate the needs of the regional patient population and community.

The project will expand the availability of primary care in our community through the addition of new primary care clinics. The clinics combined will require at least one new physician and at least four physician extenders (i.e. Family Nurse Practitioner or Physician Assistant). The clinics will also require multiple clinic staff and business office personnel. They will be responsible for providing care to the underserved population in the areas in which their clinic is established.

The first clinic to be established will be in the South Plains Mall. The South Plains Mall is home to nearly 2,500 employees and has an annual rate of ten million patrons that visit from a large area that encompasses most of west Texas and eastern New Mexico (150 mile radius). According to the Texas Department of Rural Affairs, 90% of the counties within a 150 mile radius of Lubbock are considered Whole County medically underserved areas or Partial County medically underserved areas. Further, according to the Health Resources and Services Administration, all New Mexico counties that border Texas are considered medically underserved. TexasTribune.org shows that the majority of counties surrounding Lubbock County have between 10% and 30% of its residents that have income levels below the poverty line.

The second clinic to be established will be located in Lubbock on the Interstate 27 corridor. Although the clinic will be open to all patients, we believe the specific target area would be the residents of the city of Lubbock that live in the following zip codes: 79401, 79403, 79404, 79411, and 79412. According to City-data.com, households within these zip codes with income levels below the poverty line are 50%, 24.2%, 28.9%, 36.4%, and 27.1% respectively. Further according to Health Resources and Services Administration, the majority of the census tracts located in these zip codes are considered medically underserved areas.

The new clinics will have the capacity to allow for more than 500 patient visits per month per clinic. The new capacity will allow patients to receive the right care at the right time in the right setting. Through these visits, chronic disease episodes and unnecessary emergency room visits will hopefully be reduced.

The number one identified community need in our region is access to primary care. As per a gap analysis performed in our community, there is an extreme shortfall in family and internal medicine providers. The gap analysis shows a projected 2015 shortfall of 10 family practice providers and 49 internal medicine providers. A recent report on Advisory.com shows that Texas is ranked 5th among states as the lowest physician to 100,000 population ratio.

Goals and Relationship to Regional Goals

Our goal is to expand the capacity of primary care to better accommodate the needs of the patient population and community. By adding two new clinics we are also adding new providers to help alleviate the deficiencies in health care of which the Texas Higher Education Coordinating Board in a 2008 report states, "If the number of physicians does not increase, the physician to population ratios will become increasingly unfavorable."

Region 12's regional goal is to fulfill as many of the identified regional community needs as possible. This project meets the number on regional community need identified: CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care. This project will bring the right care, in the right setting, at the right time. Focusing on transforming health care delivery from a disease-focused model of episodic care to a patient centered. By increasing access to primary care we hope to improve patient satisfaction, health outcomes, reduce unnecessary ED visits.

Challenges

Challenges for our community are the lack of access to healthcare from a provider standpoint and a facility standpoint. Patients are more apt to seek healthcare when accessibility is more convenient. Having to struggle to find healthcare often deters the patient from seeking necessary treatment. Further complicating the access for healthcare is the ability to find providers and facilities that will provide treatment to patients that have Medicaid or are unfunded. By opening these two clinics we are addressing both issues mentioned above. Both locations will be provide convenient access to healthcare to both Medicaid and unfunded patients. There are several internal challenges for this initiative. For the clinic at the mall, the challenge will be convincing patients that seeking treatment in a retail sales area is feasible. This will be the first mall clinic of its kind in west Texas. This new, innovative way to reach patients will be successful once patients open up to the idea that this is a viable means to receive healthcare. For the clinic on Interstate 27, the challenge will be, similar to the mall, getting patients to accept the clinic as a viable means to receive healthcare. Demographic studies from the emergency room suggest that patients from these zip codes tend to want to seek health care via the emergency room. Convincing them that this is a more effective and efficient way is imperative for success. Using another clinic in the area as a case study, it took nearly three years before patient volume was at a feasible level (i.e. patients' acceptance of the clinic). We will be addressing the above mentioned challenges by providing as much education and outreach to the targeted areas as possible. Free health screens and health fairs will be made available in these areas. Targeted marketing will be used to draw in patients from these areas.

5-Year Expected Outcome

We would expect over the next five years to establish two new clinics . The clinics would have a combined capacity to have 27,000 visits annually. We would expect to be at 46% capacity by the end of DY5. Region 12's goals are to fulfill all community needs identified in our needs assessment. While we know that not all of these goals will be achievable during the waiver time period, this project will move us closer to filling the gap in primary care capacity need. This need is the most critical need in our region.

Starting Point/Baseline:

Currently, neither of the above mentioned clinics exists. These are both new initiatives. Therefore, the baseline for the number of new clinics and visits at these clinics begins at 0 in DY2.

Rationale:
The reason we selected this project option is because our community, as elsewhere, a significant number of people use an emergency care center as their primary care provider thus increasing the healthcare cost related to primary care. Due to shortage of access to primary care also creates episodic care treatment in the EC. Further, according to a community needs assessment done by a local health system, as well as the RHP12 community needs assessment (CN1), there is a severe shortage of primary care providers and a lack of access to primary care. Without access to primary care, chronic conditions are likely to become acute episodes, putting patients at risk. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care, and discourage people from using health care proactively. Based on data from other clinics in similar settings, we feel that we will be able to reach uninsured, low income and Medicaid patients. The new initiative to add two new clinics which will in turn add primary care providers which will allow us to address the shortage of providers and to allow patients to receive the right care at the right time in the right setting. The Milestones and Metrics are relevant because of the strategic location of each new clinic; we will be able to make health care more readily available to uninsured and Medicaid patients. By measuring the volume at each clinic, we can assure that our clinics are successful at providing access to primary care.

Unique community need identification numbers the project addresses:
CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Both clinics are new initiatives. Both clinics will serve unique populations that studies show are challenged by income levels and access to health care.

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Chronic Disease Outcomes:
IT-1.7 Controlling high blood pressure – number of patients with BP less than 140/90mm HG
These new primary care clinics will serve many patients in need, including Medicaid and uninsured patients. We will use these clinics to focus efforts on the high incidence of diabetes and heart disease (CN4). Category 3, IT-1.7 deals with controlling blood pressure. We will establish a baseline of at-risk patients for those with BP <140/90mm Hg. Once a baseline is determined, we will then create a plan to help reduce the percentage of at-risk patients. By using our clinics and focusing on hypertension management, we expect to improve health care of our patients by providing them the right care in the right setting. Regularly scheduled health care in a primary care setting as opposed to emergent setting will be more effective and efficient for the patient and the health system.

Relationship to other Projects:

This project, 1.1 expanding primary care capacity will assist our other initiatives of 1.3 implement and utilize chronic disease management registry and 2.2 expand chronic care management models.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face to face meetings, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Triple Aim goals are directly impacted by expanding the number of clinics, i.e. access to health care where patients can receive the right care at the right time and in the right setting. By expanding the number of clinics available, we will give patients, including those using Medicaid and uninsured, more options which will encourage them to seek health care in non-emergency settings.	5
Addresses Community Need(s)	Access to primary care is the #1 community need in our region per the RHP12 needs assessment. By expanding the number of clinics, Medicaid and uninsured patients will have more options to seek health care.	5
Project Scope/Size	We expect to increase primary care capacity. The increased access to primary care is expected to decrease usage of the ER for level 1 and 2 visits. We would expect patient visits at these two new clinics to gradually increase over each year in their first few years of existence.	5
Project Investment	The investment is significant as new clinics have many startup costs including lease/land agreements, construction, fixed and movables and new staffing. Volume levels early on will not be enough to sustain the clinics on their own. The health care system will have to subsidize any losses by the clinics until they can become financially sustainable.	5

079877902.1.1	1.1.1	N/A	Establish more primary care clinics
UMC Physician Network Services		079877902	
Related Category 3 Outcome	079877902.3.2	3.IT-1.7	Controlling High Blood Pressure

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
1.Process Milestone P-1: Establish additional primary care clinic **P-1.1 Metric:** Number of additional clinics: 1 **Goal/Baseline:** Goal will be to open one new clinic in DY2. Baseline will be zero patients with a capacity to see 12,000 visits annually. **Data Source:** Documentation of new facility and hours of operation and number of encounters in DY2. **Estimated Milestone 1 Payment:** $ 1,308,212	**2.Process Milestone P-1:** Establish additional primary care clinic **P-1.1 Metric:** Number of additional clinics: 1 **Goal/Baseline:** Goal will be to open one new clinic in DY3. Baseline will be zero patients with a capacity to see 15,000 visits annually. **Data Source:** Documentation of new facility and hours of operation. **Estimated Milestone 2 Payment:** $687,611.5 **3.Improvement Milestone I-12:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services **I-12.1 Metric:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Goal/Baseline**: We expect to utilize 33% of the SPMall Clinic capacity which would equal 4,000 visits in DY3. **Data Source:** Practice management	**4.Improvement Milestone I-12:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **I-12.1 Metric:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period **Metric:** Total number of patients reported in DY3 vs DY4. **Goal/Baseline**: We expect to utilize 33% of the I-27 Clinic capacity which would equal 5,000 visits in DY4. For the SPMall Clinic we would expect a 25% increase in visits from DY3 which would be 5,000 total visits. (42% of capacity) **Data Source:** Practice management system. **Estimated Milestone 4**	**5.Improvement Milestone I-12:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services . **I-12.1 Metric:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Metric:** Total number of patients reported in DY4 vs DY5. **Goal/Baseline**: For the I-27 Clinic, we would expect a 25% increase in visits from DY4 which would be 6,250 total visits. (42% of capacity) For the SPMall Clinic we would expect a 25% increase in visits from DY4 which would be 6,250 total visits. (52% of capacity) **Data Source:** Practice management system. **Estimated Milestone 5 Payment:** $ 1,300,490 .

	system. **Estimated Milestone 3 Payment:** $687,611.5	**Payment:** $1,400,012	
DY 2 Estimated Milestone Bundle Amount: $1,308,212	**DY 3 Estimated Milestone Bundle Amount: $** 1,375,223	**DY4 Estimated Milestone Bundle Amount:** $1,400,012	**DY5 Estimated Milestone Bundle Amount:** $1,300,490
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: 5,383,937			

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Performing Provider: StarCare Specialty Health System/084897001
Unique Project ID: 084897001.1.1
Project Components: 1.13.1 a-e

PROVIDER: StarCare Specialty Health System (StarCare) is a community center/governmental entity/public provider under Chapter 534 of the Texas Health and Safety Code, serving over 5,000 people per year with an annual budget in excess of $30,000,000.

INTERVENTIONS: StarCare will establish a Psychiatric Emergency Service Center (PESC) that offers walk-in crisis services, 48-hour extended observation for adults and 14-day extended care for adults, in order to reduce inappropriate use of physical medicine emergency departments.

NEED FOR THE PROJECT: StarCare Specialty Health System selected this project because it directly addresses the Region 12 Community Needs Assessment ID# CN2 (Critical Need) of *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact.* When a person lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Choices often come down to the emergency room, jail or an inpatient hospital stay. Crisis stabilization services create alternatives to these less desirable settings.

TARGET POPULATION: The target population to be served by this project includes people who are experiencing psychiatric crises. StarCare hopes to serves at least 600 people during this waiver, at least 95% of whom are anticipated to be Medicaid eligible or indigent.

CATEGORY 1 EXPECTED PATIENT BENEFITS: During DY3 StarCare will hire and train staff, develop all operational protocols and clinical guidelines and develop a baseline from which to calculate system improvements. During DY4 and DY5, StarCare will provide at least 420 office-based crisis screenings annually, serve an average of 240 adults in the 48-hour extended observation unit each year and serve an average of 360 adults in the 14-day extended care unit each year. Conceivably, over 600 people could be impacted by this project, with a 10% increase over baseline in utilization of this appropriate crisis alternative in DY4 and 15% in DY5.

CATEGORY 3 OUTCOMES: OD 9: Right Care, Right Setting; IT-9.2 Emergency Department appropriate utilization (Stand-Alone Measure) StarCare expects to reduce psychiatric-related Emergency Department visits from the baseline established in DY3 by 10% in DY4 and 15% in DY5.

Project Option: 1.13.1 Development of behavioral health crisis stabilization services as alternatives to hospital
Performing Provider: StarCare Specialty Health System/084897001
Unique Project ID: 084897001.1.1
Project Components: 1.13.1 a-e

Project Description:
One in four adults, approximately 57.7 million Americans, experiences a mental health disorder every year.[17] For the average family, nothing is more confusing or devastating than trying to help a loved one struggling with a mental illness. People often don't know where to go, what to do or who to ask for help. Even if they do know and despite ongoing educational efforts, stigma is still overwhelming and can be a huge barrier to getting a person the care they need. When the unthinkable happens, suicide traumatizes whole families, often for multiple generations. People should know there is hope and there is a place to go for help. In Lubbock, as throughout the rest of the country, the focus in healthcare is on decreasing cost and improving outcomes. This project proposes a methodology to accomplish both of these goals, reduction of cost through diversion of people experiencing psychiatric crises from emergency departments, inpatient settings and jail, into a more effective and efficient delivery system of care.

StarCare Specialty Health System (StarCare) will establish a Psychiatric Emergency Service Center (PESC) that offers walk-in crisis services, 48-hour extended observation for adults and 14-day extended care for adults. The PESC offers short-term interventions for people who are experiencing psychiatric crises secondary to severe stressors, family issues, housing challenges, etc., but who are not at immediate risk of harm to themselves or others. The PESC will provide a normalized environment in which the primary objectives are crisis resolution and psychiatric stabilization. The PESC will serve as a "step down" alternative to emergency department use, psychiatric hospital admission and jail and as a "back door" placement for people who are able to be discharged from a psychiatric hospital or jail, but who may not be ready to return home. The target population to be served in this program is people in need of psychiatric crisis stabilization. At least 95% of people in need of crisis intervention are Medicaid eligible or indigent, so one can expect they will benefit from a commensurate percentage of services. Following is a description of each facet of this project:

Walk-In Crisis Services:
- Continuously available service 24 hours a day, 365 days a year; projected to provide 420 office-based crisis screenings annually
- Office-based screenings by clinical professionals who provide prompt face-to-face assessment, evaluation and crisis resolution services, including emergency care, urgent care, crisis follow-up and relapse prevention
- Designed specifically for crisis resolution and linkage to appropriate care

48-Hour Extended Observation for Adults (18 years and Older):
- Offers psychiatric assessment, medication administration, supervision and monitoring for up to 48 hours for adults who might

[17] *NIMH: The numbers count—Mental Disorders in America,* National Institute of Health, available at www.nimh.nih.gov/publicat/numbers.cfm

otherwise be hospitalized; projected to serve a minimum of 20 adults per month
- Planned capacity is a 20-bed, secure (locked) unit; Admissions can be voluntary or involuntary
- Psychiatrist sees every adult within 2 hours of admission; Physician Assistant sees every adult daily while admitted
- Offers discharge to a lower level of community care for 60% of adults served

14-Day Extended Care for Adults (18 years and Older):
- Offers crisis resolution and treatment monitoring for up to 14 days for adults who are in need of support; projected to serve an average of 30 adults per month
- Focus is upon crisis prevention and intervention planning, medication monitoring and management and rehabilitation activities
- Planned capacity is a 30-bed, unlocked unit; admissions are voluntary
- Physician Assistant sees every adult daily while admitted
- Offers discharge to a lower level of community care for 90% of adults served

Goal of Project: The primary goal of this project is to ensure people receive coordinated, timely and site-appropriate behavioral health services. Specifically, StarCare will assist with diverting non-urgent care from EDs, inpatient psychiatric hospitals and jails to a site-appropriate location.

Challenges: StarCare Specialty Health System is often informed of a person in crisis, after he/she has been treated in an emergency department or detained by law enforcement. StarCare will develop and implement a comprehensive public information campaign targeted to families, care providers, social service agencies, law enforcement, etc. educating them about the availability of this alternative.

5-Year Expected Outcome for Performing Provider and Patients:
- Performing Provider Perspective – improved healthcare infrastructure that better serves the Medicaid-funded and uninsured residents of our counties; coordinated care delivery system; improved efficiency and cost growth containment.
- Patient Perspective – high quality, patient-centered care; improved access to coordinated healthcare; improved health outcomes.

Relationship to Regional Goals: Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The resulting document ranked the needs in tiers, according to the availability of evidence documenting each need. Tier one included the two (2) most pressing needs in RHP 12: 1) a severe lack of primary care access including provider shortages, financial barriers, wait times, and length of time to get an appointment;

and 2) a lack of mental health services including lack of available appointments, insurance coverage, and emergency room usage for mental health issues. Tier two identified other priority issues as: 1) uninsured and underinsured; 2) high incidence of obesity, diabetes, and heart disease; 3) need for specialty care; and 4) need for cancer screenings; and 5) insufficient maternal and prenatal care. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement.

StarCare's PESC project directly relates to the Region 12 goals of increased access to care and increased prevention and early detection activities. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.

Starting Point/Baseline: StarCare does not currently operate a PESC; therefore, the starting point/baseline for the number of people to be assisted is zero.

Reason/Rationale for Selecting Measure: The following Project Option and Project Components were selected because they directly address Region 12 Community Needs Assessment ID# CN2 (Critical Need): *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* Inadequate crisis services for adults with mental illness have long been an identified gap in the Lubbock continuum of health care. Currently, people experiencing psychiatric crises have limited options available for care: emergency rooms, inpatient hospitals and jails. While emergency room treatment is necessary for serious physical/medical needs, inpatient hospitalization is necessary to ensure individual safety and incarceration is necessary for some classes of crimes, a PESC will offer a more cost-effective and clinically appropriate alternative in many circumstances. Patients with mental illness overuse emergency rooms when appropriate mental health care is not available. In one study, 25-30% of people presenting to emergency rooms were really there because of non-emergent mental health issues, resulting in unnecessary cost.[18] Additionally, individuals with mental illness remain in the emergency room longer, decreasing access for others with medical emergencies. As a result of limited appropriate emergency mental health interventions, individuals who exhibit acute difficulties and behaviors are frequently shuttled between emergency rooms, law enforcement agencies, public and state psychiatric hospitals, state supported living centers and nursing home or other institutions, with little or no continuity of care. This results in costly inpatient interventions that lack efficacy and fail to meet the long-term needs of the target population in the community. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services, based upon the needs of the people served. While hospitalization provides a high degree of safety

[18] http://link.springer.com/article/10.1007%2Fs10597-012-9523-0?LI=true

for a person in crisis, it is very expensive and is often more than what is needed to address the crisis. In Texas, State Mental Health Facilities are considerably more expensive than community-based services, costing an average of $401 per day. The average length of stay in the State Mental Health Facility System is 29 days and the cost of an average stay is $11,629. Incarcerating a person who has a serious mental illness can cost taxpayers around 3 times as much as jailing other inmates without mental illness. The average daily cost for an inmate with severe mental illness is $137. The average length of stay in jail for a person with mental illness is 80 days. The total average cost for an inmate with mental illness costs $10,960. In addition to higher costs, inmates with mental illness also tend to stay in jail longer than the general inmate population. Without access to critical community-based mental health services like medications and case management, individuals with serious mental illness cannot manage their illness and are more likely to engage in behaviors that cause contact with the criminal justice system.[19] Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. The PESC will create an alternative to these less desirable settings.

Core Project Components:

a. StarCare will convene community stakeholders who can support the development of the PESC services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.
b. StarCare will analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.
c. StarCare will assess the behavioral health needs of people currently receiving crisis services in emergency departments, psychiatric hospitals or in jail, in order to determine the types and volume of services needed to resolve crises in the PESC.
d. StarCare will explore potential crisis alternative service models in order to determine the most acceptable and feasible model for implementation.
e. StarCare will conduct Continuous Quality Improvement (CQI) activities using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. Our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

[19] http://www.ttbh.org/Documents/BudgetCutsCommunity.pdf

Unique Community Need ID#: CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 Poor insurance support or uninsured.

Milestones & Metrics:
The milestones (1.13.1 – P-1, P-2, P-3, P-5 and 1.13.1 – I-12) and metrics (1.131.1 – P-1.1, P-2.1, P-4.1, P-5.1 and 1.13.1 I-12.1) were selected because of their applicability to CN2 and CN3, outlined in the Region 12 Community Needs Assessment.

Related Category 3 Outcome Measure: OD-9 Right Care, Right Setting; IT-9.2 ED appropriate utilization (standalone measure)/Reduce ED visits for target conditions (Behavioral Health/Substance Abuse) StarCare expects to reduce Emergency Department visits from the baseline established in DY3 (# of psychiatric-related ED visits that could have been made to the PESC instead) by 10% in DY4 and 15% in DY5.

Reasons/Rationale for Selection: According to the Region 12 Community Needs Assessment, an appropriate alternative to EDs is a "Critical Need."

Explanation of how focusing on the outcomes will help improve the health of low-income populations: StarCare hopes to address the healthcare disparity of unequal access for people with low-income. Establishment of a PESC will allow people access to specialized interventions during psychiatric crises, diagnosis-specific after care services and referrals.
Relationship to Other Projects: All of StarCare's projects are related in that they focus on the same goals: increased access to needed healthcare in the most appropriate setting. StarCare's other project is:

- 084897001.1.2 – establish an Adolescent Crisis Respite Program

Relationship to Other Performing Providers' Projects in RHP & Plan for Learning Collaborative: Several performing providers in Region 12 are planning to implement projects aimed at diverting people from emergency departments and inpatient settings; however, StarCare appears to be the only performing provider focused upon people experiencing psychiatric crises. As stated above, our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score

Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure people receive coordinated, timely and site-appropriate healthcare services. StarCare hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	5
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. StarCare's PESC directly relates to the Region 12 goals of CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 (Urgent Need) Poor insurance support or uninsured.	5
Project Scope/Size Scale: 1 to 5 5 Greatest	During DY4 and DY5, StarCare will provide at least 420 office-based crisis screenings annually, serve an average of 240 adults in the 48-hour extended observation unit each year and serve an average of 360 adults in the 14-day extended care unit each year. Conceivably, over 600 people could be impacted by this project, with a 10% increase from baseline in utilization of this appropriate crisis alternative in both DY4 and 15% in DY5. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	4
Project Investment Scale: 1 to 5 5 Greatest	StarCare's investment in this project will be fairly significant. Staffing will include a Program Director, Psychiatrist, Registered Nurses, Qualified Mental Health Professionals, Human Service Technicians, an Administrative Assistant, etc. (shared with other, similar programs, for the purpose of economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc.	4

08487001.1.1	1.13.1	1.13.1 a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
StarCare Specialty Health System		**084897001**	
Related Category 3 Outcome Measure(s):	**084897001.3.1**	**IT-9.2**	**ED Appropriate Utilization**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-1]: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health service providers. **Metric(s):** [P-1.1] Number of meetings and participants **Baseline/Goal:** No less than 3 meetings **Data Source:** Attendance lists **Milestone 1 Estimated Incentive Payment:** $1,339,669 **Milestone 2:** [P-2]: Conduct mapping and gap analysis of current crisis system **Metric(s):** [P-2.1] Produce a written analysis of community needs for crisis services **Baseline/Goal:** Written Plan	**Milestone 3:** [P-4]: Hire and train staff to implement identified crisis stabilization services. **Metric(s):** [P-4.1] Number of staff hired and trained **Baseline/Goal:** At least 95% of staff needed to open **Data Source:** Staff rosters and training records and training curricula **Milestone 3 Estimated Incentive Payment:** $980,748 **Milestone 4:** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services **Metric(s):** [P-5.1] Completion of policies and procedures **Baseline/Goal:** Written manual **Data Source:** Internal policy and procedures documents and operations manual.	**Milestone 6:** [I-12]: Utilization of appropriate crisis alternative **Metric(s):** [I-12.1] 10% increase in utilization of appropriate crisis alternative. **Baseline:** Will be established in DY3 **Goal:** DY4 =Increase utilization of Crisis Respite Unit by 10% over Baseline **Data Source:** Claims, encounter and clinical record data **Milestone 6 Estimated Incentive Payment:** $1,573,725 **Milestone 7:** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric(s):** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP	**Milestone 8:** [I-12]: Utilization of appropriate crisis alternative **Metric(s):** [I-12.1] 15% increase in utilization of appropriate crisis alternative. **Baseline:** Will be established in DY3 **Goal:** DY5 =Increase utilization of Crisis Respite Unit by 15% over Baseline **Data Source:** Claims, encounter and clinical record data **Milestone 8 Estimated Incentive Payment:** $1,520,535 **Milestone 9:** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric(s):** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP

Data Source: Written Plan **Milestone 2 Estimated Incentive Payment:** $1,339,669	**Milestone 4 Estimated Incentive Payment:** $980,748 **<u>Milestone 5:</u>** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric(s):** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline = Not Applicable Goal = Participate in 2 meetings/yr **Data Source:** Attendance rosters, agendas, slides, minutes **Milestone 5 Estimated Incentive Payment:** $980,748	**Baseline/Goal:** Baseline = Not Applicable Goal = Participate in 2 meetings/yr **Data Source:** Attendance rosters, agendas, slides, minutes **Milestone 7 Estimated Incentive Payment:** $1,573,725	**Baseline/Goal:** Baseline = Not Applicable Goal = Participate in 2 meetings/yr **Data Source:** Attendance rosters, agendas, slides, minutes **Milestone 9 Estimated Incentive Payment:** $980,748
DY 2 Estimated Milestone Bundle Amount: $2,679,338	**DY 3 Estimated Milestone Bundle Amount:** $2,942,244	**DY4 Estimated Milestone Bundle Amount:** $3,147,450	**DY5 Estimated Milestone Bundle Amount:** $3,041,070
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $11,810,102			

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Performing Provider: StarCare Specialty Health System/084897001
Unique Project ID: 084897001.1.2 – **"Pass 2"**
Project Components: 1.13.1 a-e

PROVIDER: StarCare Specialty Health System (StarCare) is a community center/governmental entity/public provider under Chapter 534 of the Texas Health and Safety Code, serving over 5,000 people per year with an annual budget in excess of $30,000,000. StarCare will collaborate with the Helen Farabee Community Center, also a governmental entity/public provider under Chapter 534 above, to include services for adolescents from four (4) of its service area counties (Dickens, King, Cottle and Childress.)

INTERVENTIONS: During Pass 2, StarCare will expand its Pass 1 project [which included the establishment of a Psychiatric Emergency Service Center (PESC) offering walk-in crisis services, 48-hour extended observation for adults and 14-day extended care for adults] to include an Adolescent Crisis Respite Program.
NEED FOR THE PROJECT: StarCare selected this project because it directly addresses the Region 12 Community Needs Assessment ID# CN2 (Critical Need) of *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact.* By collaborating with the Helen Farabee Center, StarCare will be able to serve even more adolescents and, therefore, avoid even more inappropriate emergency department use. The collaboration is transformative because it will allow access to lower-cost services (adolescent crisis respite) than are otherwise available (inpatient psychiatric services.) When a family lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to an emergency room, a juvenile justice detention center or psychiatric inpatient hospitalization. Crisis respite services create an alternative to these less desirable settings.
TARGET POPULATION: The target population to be served by this project includes adolescents in need of psychiatric crisis respite. This project seeks to serve at least 60 adolescents annually, 120 adolescents during the waiver. At least 95% of patients in need of crisis intervention are Medicaid eligible or indigent, so one can expect they will benefit from a commensurate percentage of services.
CATEGORY 1 EXPECTED PATIENT BENEFITS: During DY3 StarCare will hire and train staff, develop all operational protocols and clinical guidelines and develop a baseline from which to calculate system improvements. During DY4 and DY5, at least 60 adolescents per year will receive crisis respite services, with a 10% increase over baseline in utilization of this appropriate crisis alternative in DY4 and 15% over baseline in DY5.
CATEGORY 3 OUTCOMES: OD 9: Right Care, Right Setting; IT-9.2 Emergency Department appropriate utilization (Stand-Alone Measure) StarCare expects to reduce Emergency Department visits from the baseline established in DY3 (# of psychiatric-related ED visits that could have been made in an adolescent crisis-respite facility instead) by 10% in DY4 and 15% in DY5.

Project Option: 1.13.1 Development of behavioral health crisis stabilization services as alternatives to hospital
Performing Provider: StarCare Specialty Health System/084897001
Unique Project ID: 084897001.1.2 – **"PASS 2"**
Project Components: 1.13.1 a-e

Project Description: Twenty percent of youth (20%) are affected by a mental disorder sometime in their lifetime.[20] According to a 2011 longitudinal study conducted by the Centers for Disease Control and Prevention the number of teen suicides has been increasing in recent years. In 2011 alone, 15.8% of teens (grades 9 – 12) surveyed had seriously considered attempting suicide, 12.8% had made a plan about how they would attempt suicide, 7.8% actually attempted suicide one or more times and 2.4% had suicide attempts resulting in injury, poisoning or overdose requiring treatment by a doctor or nurse.[21] For the average family, trying to help a child struggling with a severe emotional disturbance or mental illness is confusing and frustrating. Parents and caregivers often don't know where to go, what to do or who to ask for help. Even if they do know and despite ongoing educational efforts, stigma is still overwhelming and can be a huge barrier to getting children the care they need. When the unthinkable happens, suicide traumatizes whole families, often for multiple generations. Families should know there is hope and there is a place to go for help. In Lubbock, as throughout the rest of the country, the focus in healthcare is on decreasing cost and improving outcomes. This project proposes a methodology to accomplish both of these goals, reduction of cost through diversion of adolescents experiencing psychiatric crises from emergency departments, inpatient settings and juvenile justice detention centers, into a more effective and efficient delivery system of care.

During Pass 2, StarCare Specialty Health System (StarCare) will expand its Pass 1 project [which included the establishment of a Psychiatric Emergency Service Center (PESC) offering walk-in crisis services, 48-hour extended observation for adults and 14-day extended care for adults] to include an Adolescent Crisis Respite Program. The adolescent crisis respite program will offer short-term interventions for youth who are experiencing psychiatric crises secondary to severe stressors, family issues, school challenges, etc., but who are not at immediate risk of harm to themselves or others. The adolescent crisis respite program will provide a normalized environment in which the primary objectives are crisis resolution and psychiatric stabilization. The adolescent crisis respite program will serve as a "step down" alternative to emergency department use, juvenile justice detention, psychiatric hospital admission and as a "back door" placement for youth who are able to be discharged from a psychiatric hospital, but who may not be ready to return home. The target population to be served in this program is adolescents in need of psychiatric crisis respite. At least 95% of adolescents in need of crisis intervention are Medicaid eligible or indigent, so one can expect they will benefit from a commensurate percentage of services.

[20] http://www.nimh.nih.gov/science-news/2012/survey-finds-more-evidence-that-mental-disorders-often-begin-in-youth.shtml
[21] http://www.cdc.gov/HealthyYouth/yrbs/factsheets/index.htm

During Pass 2, StarCare will collaborate with the Helen Farabee Center (another Region 12 Performing Provider) in order to provide services to adolescents residing in four (4) counties historically serviced by the Helen Farabee Center: Dickens, King, Cottle and Childress. The amount of funding allocated to the Helen Farabee Center in Pass 2 was insufficient for it to implement a stand-alone project; therefore it reached out to StarCare to collaborate and serve more people than either could serve independently. The collaboration is transformative because it will allow access to lower-cost services (adolescent crisis respite) than are otherwise available (inpatient psychiatric services.) There is no question as to the permissibility of this collaboration as both organizations are governmental entities/public providers under Chapter 534 of the Texas Health and Safety Code.

To summarize, StarCare's Adolescent Crisis Respite Program will offer an alternative to use of emergency departments; offer crisis resolution and out-of-home treatment monitoring for up to 14 days for adolescents who might otherwise be hospitalized outside of their community; provide a safe, supportive environment for adolescents while immediate crises are resolved; offer discharge to a lower level of community care for adolescents served and will serve at least five (5) adolescents a month, at least 60 adolescents per year.
During Pass 2, StarCare Specialty Health System (StarCare) will collaborate with the Helen Farabee Center (another Region 12 Performing Provider) in order to provide services to adolescents residing in four (4) counties historically served by the Helen Farabee Center: Dickens, King, Cottle and Childress. The amount of funding allocated to the Helen Farabee Center in Pass 2 was insufficient for it to implement a stand-alone project; therefore it reached out to StarCare to collaborate and serve more people than either could serve independently. The collaboration is transformative because it will allow access to lower-cost services (adolescent crisis respite) than are otherwise available (inpatient psychiatric services.) There is no question as to the permissibility of this collaboration as both organizations are governmental entities/public providers under Chapter 534 of the Texas Health and Safety Code.

Goal of Project: The primary goal of this project is to ensure adolescents receive coordinated, timely and site-appropriate behavioral health services. Specifically, StarCare will assist with diverting non-urgent care from emergency departments, juvenile justice detention centers and inpatient psychiatric hospitals to a site-appropriate location.

Challenges: StarCare is often informed of an adolescent in crisis, after he/she has been treated in an emergency department or detained by law enforcement. StarCare will develop and implement a comprehensive public information campaign targeted to parents, families, care providers, schools, law enforcement, etc. educating them about the availability of this alternative.

5-Year Expected Outcome for Performing Provider and Patients:

- Performing Provider Perspective – improved healthcare infrastructure that better serves the Medicaid-funded and uninsured residents of our counties; coordinated care delivery system; improved efficiency and cost growth containment.
- Patient Perspective – high quality, patient-centered care; improved access to coordinated healthcare; improved health outcomes.

Relationship to Regional Goals: Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The resulting document ranked the needs in tiers, according to the availability of evidence documenting each need. Tier one included the two (2) most pressing needs in RHP 12: 1) a severe lack of primary care access including provider shortages, financial barriers, wait times, and length of time to get an appointment; and 2) a lack of mental health services including lack of available appointments, insurance coverage, and emergency room usage for mental health issues. Tier two identified other priority issues as: 1) uninsured and underinsured; 2) high incidence of obesity, diabetes, and heart disease; 3) need for specialty care; and 4) need for cancer screenings; and 5) insufficient maternal and prenatal care. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement.

StarCare's Adolescent Crisis Respite Program directly relates to the Region 12 goals of increased access to care and increased prevention and early detection activities. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.

Starting Point/Baseline: StarCare does not currently operate an Adolescent Crisis Respite Program; therefore, the starting point/baseline for the number of people to be assisted is zero.

Reason/Rationale for Selecting Measure: The following Project Option and Project Components were selected because they directly address Region 12 Community Needs Assessment ID# CN2 (Critical Need): *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.*

When a family lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to an emergency room, juvenile justice detention center or psychiatric inpatient hospitalization. Crisis respite services create an alternative to these less desirable settings. In one study, 25-30% of people presenting to emergency rooms were really there because of non-emergent mental health issues, resulting in unnecessary cost.[22]

[22] http://link.springer.com/article/10.1007%2Fs10597-012-9523-0?LI=true

Building on existing systems, communities can develop lower cost crisis respite programs with varying degrees of clinical services, based upon the needs of the adolescents to be served. While hospitalization provides a high degree of safety for an adolescent in crisis, it is very expensive and is often more intensive than what is needed to address the crisis. Community-based crisis respite alternatives can effectively reduce these expensive and undesirable outcomes. The Stepping Stone Crisis Respite Center in Claremont, New Hampshire estimates their respite cost to be $200 per day, compared to an average inpatient cost of $500 per day.[23] StarCare currently provides respite for adults and children diagnosed with intellectual disabilities; the average cost per day of in that program is $134.92. StarCare anticipates the average cost per day, per person in the adolescent crisis respite program to be close to $250 – well below the cost of inpatient hospitalization.

If not adequately treated in adolescence, serious emotional disturbance can turn into severe and persistent mental illness in adulthood. Adult services are very expensive and provide insight into what can be avoided by effective and efficient adolescent services. In Texas, State Mental Health Facilities are considerably more expensive than community-based services, costing an average of $401 per day. The average length of stay in the State Mental Health Facility System is 29 days and the cost of an average stay is $11,629. Incarcerating a person who has a serious mental illness can cost taxpayers up to 3 times as much as jailing inmates without mental illness. The average daily cost for an inmate with severe mental illness is $137. The average length of stay in jail for a person with mental illness is 80 days. The total average cost for an inmate with mental illness costs $10,960. In addition to higher costs, inmates with mental illness also tend to stay in jail longer than the general inmate population. Without access to critical community-based mental health services like medications and case management, individuals with serious mental illness cannot manage their illness and are more likely to engage in behaviors that cause contact with the criminal justice system.[24]

Core Project Components:

f. StarCare will convene community stakeholders who can support the development of the adolescent crisis respite services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.
g. StarCare will analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.
h. StarCare will assess the behavioral health needs of adolescents currently receiving crisis services in emergency departments, juvenile justice detention centers or psychiatric hospitals in order to determine the types and volume of services needed to resolve crises in the crisis respite unit.
i. StarCare will explore potential crisis alternative service models in order to determine the most acceptable and feasible model for implementation.

[23] http://www.power2u.org/articles/selfhelp/step_stone.html
[24] http://www.ttbh.org/Documents/BudgetCutsCommunity.pdf

j. StarCare will conduct Continuous Quality Improvement (CQI) activities using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. Our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Unique Community Need ID#: CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 Poor insurance support or uninsured.

Milestones & Metrics:
The milestones (1.13.1 – P-1, P-2, P-3, P-5 and 1.13.1 – I-12) and metrics (1.131.1 – P-1.1, P-2.1, P-4.1, P-5.1 and 1.13.1 I-12.1) were selected because of their applicability to CN2 and CN3, outlined in the Region 12 Community Needs Assessment.

Related Category 3 Outcome Measure: OD-9 Right Care, Right Setting; IT-9.2 ED appropriate utilization (standalone measure)/Reduce ED visits for target conditions (Behavioral Health/Substance Abuse) StarCare expects to reduce Emergency Department visits from the baseline (# of psychiatric-related ED visits that could have been made in an adolescent crisis-respite facility instead) established in DY3 by 10% in DY4 and 15% in DY5.

Reasons/Rationale for Selection: According to the Region 12 Community Needs Assessment, an appropriate alternative to EDs is a "Critical Need."

Explanation of how focusing on the outcomes will help improve the health of low-income populations: StarCare hopes to address the healthcare disparity of unequal access for people with low-income. Establishment of an adolescent crisis respite program will allow people access to specialized interventions during psychiatric crises, diagnosis-specific after care services and referrals.

Relationship to Other Projects: All of StarCare's projects are related in that they focus on the same goals: increased access to needed healthcare in the most appropriate setting. StarCare's other project is:

- 084897001.1.1 – establish a Psychiatric Emergency Service Center (PESC)

Relationship to Other Performing Providers' Projects in RHP & Plan for Learning Collaborative: Several performing providers in Region 12 are planning to implement projects aimed at diverting people from emergency departments and inpatient settings; however,

StarCare appears to be the only performing provider focused upon adolescents in psychiatric crisis. As stated above, our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure adolescents receive coordinated, timely and site-appropriate healthcare services. StarCare hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	5
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. StarCare's Adolescent Crisis Respite Program directly relates to the Region 12 goals of CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 (Urgent Need) Poor insurance support or uninsured.	5
Project Scope/Size Scale: 1 to 5 5 Greatest	StarCare plans to serve at least 60 adolescents per year in the Crisis Respite Program. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	4
Project Investment Scale: 1 to 5 5 Greatest	StarCare's investment in this project will be fairly significant. Staffing will include a Program Director, Psychiatrist, Registered Nurses, Qualified Mental Health Professionals, Human Service Technicians, an Administrative Assistant, etc. (shared with other, similar programs, for the purpose of economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc.	4

084897001.1.2 – "PASS 2"	1.13.1	1.13.1 a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	
StarCare Specialty Health System				**084897001**
Related Category 3 Outcome Measure(s): OD-9; IT-9.2	**084897001.3.2**	**IT-9.2**	**ED Appropriate Utilization**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: [P-1]: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health service providers. **Metric(s):** [P-1.1] Number of meetings and participants **Baseline/Goal:** No less than 3 meetings **Data Source:** Attendance lists **Milestone 1 Estimated Incentive Payment:** $207,760 **Milestone 2:** [P-2]: Conduct mapping and gap analysis of current crisis system **Metric(s):** [P-2.1] Produce a written analysis of community needs for crisis services **Baseline/Goal:** Written Plan	**Milestone 3:** [P-4]: Hire and train staff to implement identified crisis stabilization services. **Metric(s):** [P-4.1] Number of staff hired and trained **Baseline/Goal:** At least 95% of staff needed to open **Data Source:** Staff rosters and training records and training curricula **Milestone 3 Estimated Incentive Payment:** $145,602 **Milestone 4:** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services **Metric(s):** [P-5.1] Completion of policies and procedures **Baseline/Goal:** Written manual **Data Source:** Internal policy and procedures documents and operations manual.		**Milestone 6:** [I-12]: Utilization of appropriate crisis alternative **Metric(s):** [I-12.1] 10% increase in utilization of appropriate crisis alternative. **Baseline:** Will be established in DY3 **Goal:** DY4 =Increase utilization of Crisis Respite Unit by 10% over Baseline **Data Source:** Claims, encounter and clinical record data **Milestone 6 Estimated Incentive Payment:** $222,339 **Milestone 7:** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric(s):** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP	**Milestone 8:** [I-12]: Utilization of appropriate crisis alternative **Metric(s):** [I-12.1] 20% increase in utilization of appropriate crisis alternative. **Baseline:** Will be established in DY3 **Goal:** DY5 =Increase utilization of Crisis Respite Unit by 15% over Baseline **Data Source:** Claims, encounter and clinical record data **Milestone 8 Estimated Incentive Payment:** $206,534 **Milestone 9:** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric(s):** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP

084897001.1.2 – "PASS 2"	1.13.1	1.13.1 a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	
StarCare Specialty Health System				**084897001**
Related Category 3 Outcome Measure(s): OD-9; IT-9.2	**084897001.3.2**	**IT-9.2**	**ED Appropriate Utilization**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Written Plan **Milestone 2 Estimated Incentive Payment:** $207,760	**Milestone 4 Estimated Incentive Payment:** $145,601 **Milestone 5:** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric(s):** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline = Not Applicable Goal = Participate in 2 meetings/yr **Data Source:** Attendance rosters, agendas, slides, minutes **Milestone 5 Estimated Incentive Payment:** $145,670		**Baseline/Goal:** Baseline = Not Applicable Goal = Participate in 2 meetings/yr **Data Source:** Attendance rosters, agendas, slides, minutes **Milestone 7 Estimated Incentive Payment:** $222,338	**Baseline/Goal:** Baseline = Not Applicable Goal = Participate in 2 meetings/yr **Data Source:** Attendance rosters, agendas, slides, minutes **Milestone 9 Estimated Incentive Payment:** $206,533
Year 2 Estimated Milestone Bundle Amount: $415,520	**Year 3 Estimated Milestone Bundle Amount:** $436,804		**Year 4 Estimated Milestone Bundle Amount:** $444,677	**Year 5 Estimated Milestone Bundle Amount:** $413,067
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,710,067				

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Performing Provider: Texas Panhandle Centers Behavioral and Developmental Health/127378105
RHP Unique Identification Number: 127378105.1.1
Project Components: 1.13.1.a-e

- **Provider:** Texas Panhandle Centers Behavioral and Developmental Health is a local mental health authority providing behavioral and developmental health services in the top 21 counties of the Texas Panhandle, an area of over 21,000 square miles with a population of approximately 400,000.
- **Intervention(s):** Provision of a 24 hour 7 day a week Crisis Respite program for persons with behavioral health needs residing in the upper 21 counties of the Panhandle of Texas that will serve as a community care alternative to more costly inpatient hospitalization and incarceration, focusing on rapid stabilization and averting future crises.
- **Need for the project:** There are no behavioral health crisis respite programs for adults in the local service area. The Crisis Respite Program will address both Critical Needs identified in the RHP 12 Needs Assessment Summary- Community Needs Identification: CN.1 (wait time, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as CN.3 (Poor insurance support or uninsured).
- **Target population:** The target population is adults with behavioral health needs in need of crisis respite in the top 21 counties of the Texas Panhandle. Approximately 90% of our clients are either Medicaid eligible or indigent. We anticipate enrolling 72 patients in our program in DY4, and enrolling 86 patients in DY5.
- **Category 1 or 2 expected patient benefits**: 5% increase in utilization of appropriate crisis alternatives DY4 and 6% increase in utilization of appropriate crisis alternatives DY5.
- **Category 3 outcomes:** IT-10.1 Our goal is to demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD %

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Performing Provider: Texas Panhandle Centers Behavioral and Developmental Health/127378105
RHP Unique Identification Number: 127378105.1.1
Project Components: 1.13.1.a-e

Project Description: Crisis Respite Program- Texas Panhandle Centers Behavioral and Developmental Health, as a provider of behavioral health services to children and adults across the top 21 counties of the Texas Panhandle, proposes to provide a 24 hour 7 day a week Crisis Respite program for persons with behavioral health needs residing in the upper 21 counties of the Panhandle of Texas that will serve as a community care alternative to more costly inpatient hospitalization and incarceration, focusing on rapid stabilization and averting future crises.

Project Goal: To develop a behavioral health crisis respite program that will serve as an alternative to hospitalization and incarceration, allowing local residents to remain in the community, improving their quality of life with the side benefit of reducing state hospital and incarceration costs.

This project meets the following regional goals:
The Crisis Respite Program will reach the RHP 12 Triple Aim Goals of:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

Intervening and treating a person before they are incarcerated or hospitalized is much more cost effective. The Crisis Respite Program will address both Critical Needs identified in the RHP 12 Needs Assessment Summary- Community Needs Identification: CN.1 (wait time, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as CN.3- Poor insurance support or uninsured.

Challenges: When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. The development of this crisis respite program creates alternatives to these less desirable settings. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. The closest State Hospital to Amarillo is in Wichita Falls, 225 miles away. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as

preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.

5-Year Expected Outcome: Texas Panhandle Centers expects to see improvement in quality of life for program participants, along with a reduction in crisis respite participants' hospitalization and incarceration rates.

Starting Point: Currently, a crisis respite program for persons with behavioral health needs does not exist in the local service area. Therefore, the baseline for number of participants begins at 0 in DY2.

Rationale: Persons with mental illness who have repeated contacts with area hospitals and law enforcement and have been hard to engage will receive increased treatment engagement. Persons with mental illness will see the quality of their lives improve. Stable housing, family and peer relationships, employment and education status, drug and alcohol use, and victimization will also be focused on during treatment and referral. Existing resources will be used more effectively; reducing the consumption of these limited resources among program participants is both realistic and measurable. Treatment will be provided in a less restrictive setting, avoiding disruption of consumers' ongoing involvement in the community, promoting activities in the community, offering patients respect and opportunities for self-determination, and enhancing their dignity. This program will fill a treatment gap in the community. There will be a reduction in less clinically appropriate care by targeted population when this program is implemented. The vast majority of the target population for this program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

The project will meet all of the required core components:

a) *Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.*
b) *Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.*
c) *Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings).*

d) *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.*
e) *Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations*

Process Milestones – DY2 and DY3: These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P- 2 Establish baseline rates

Improvement Target – DY4 and DY5

- IT-10.1 Quality of Life (*Standalone measure)*

Unique community needs identification numbers the project addresses:

- CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.
- CN.3- Poor insurance support or uninsured.

How the project represents a new initiative or significantly enhances an existing reform initiative:
There are currently no crisis respite services available for the target population of this project.

Related Category 3 Outcome Measure(s): *OD- 10 Quality Of Life/ Functional Status:* The basic idea of the Crisis Respite Project is providing needed behavioral health services and interventions that will improve quality of life to those in need, so we believe that measuring for improvement in quality of life can help shape services provided to be even more effective.

Relationship to other Projects: This project will support, enable, and relate to other projects in the RHP plan as listed below:

127378105.2.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. (Continuum of Care Project)- persons served in the Continuum of Care project can be immediately referred to Crisis Respite if the need is determined. The Continuum of Care project will also be a resource for persons being served by Crisis Respite.

*127378105.2.2 Integrate Primary and Behavioral Health Care Services***-** persons served through the Crisis Respite program who have behavioral and primary health care needs will have improved access to integrated primary and behavioral healthcare through

provision of this program. Also, persons served in the integrated healthcare setting can be immediately referred to Crisis Respite services if the need/appropriateness is determined during integrated care appointments.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	Relative to TPC's other proposed projects, this project ranks second in achieving the waiver goals of: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improving the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; further developing and maintaining a coordinated care delivery system; and improving outcomes while containing cost growth. The project impact all of the goals; it primarily impact Medicaid and/or uninsured residents; the expected impact is significant; and there is strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**4**
Addresses Community Need(s)	This project ranks third at addressing community needs as related to our other projects. This project addresses the following community needs identified in the RHP 12 Needs Assessment Summary: CN.1- wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact); and CN.3- Poor insurance support or uninsured.	**3**
Project Scope/Size	We believe this project will be our third largest relative to our other projects in terms of scope/size. We took into account improvements/increases in: Outreach to the targeted population; Patient visits/encounters; Providers recruited/trained; and Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**
Project Investment	Relative to our other proposed projects, the expected investment to successfully implement this project and achieve milestones and metrics will be the third largest. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**3**

127378105.1.1	1.13.1	1.13.1.a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	
Texas Panhandle Centers				**127378105**
Related Category 3 Outcome Measure(s):	**127378105.3.1**		**IT-10.1**	**Quality of Life- Standalone measure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-5. Milestone: Develop administration of operational protocols and clinical guidelines for crisis services. P-5.1. Metric: Completion of policies and procedures. Goal: Produce a comprehensive policies and procedures document. Data Source: Internal policy and procedures documents and operations manual. Milestone 1 Estimated Incentive Payment: $933,949	P-4. Milestone: Hire and train staff to implement identified crisis stabilization services. P-4.1. Metric: Number of staff hired and trained. Baseline: At the beginning of DY2, Crisis Respite program did not exist; therefore baseline is 0. Goal: Work with partners to develop the training program with procedures and continuing education. Contract with/Hire and Train 12 staff Data Source: Staff rosters and training records, Training curricula Milestone 2 Estimated Incentive Payment: $1,025,591		I-12. Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 5% increase in utilization of appropriate crisis alternatives. We estimate 72 people will receive community behavioral healthcare services from appropriate crisis alternatives Goal: 5% increase in utilization of appropriate crisis alternatives. Data source: Claims, encounter, and clinical record data. Milestone 3 Estimated Incentive Payment: $1,097,144	I-12. Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 6% increase in utilization of appropriate crisis alternatives. We estimate 86 people will receive community behavioral healthcare services from appropriate crisis alternatives Goal: 6% increase in utilization of appropriate crisis alternatives. Data source: Claims, encounter, and clinical record data. Milestone 4 Estimated Incentive Payment: $1,060,043
Year 2 Estimated Milestone Bundle Amount: $ 933,949	Year 3 Estimated Milestone Bundle Amount: $ 1,025,591		Year 4 Estimated Milestone Bundle Amount: $ 1,097,144	Year 5 Estimated Milestone Bundle Amount: $ 1,060,043
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,116,727				

Project Option: 1.9.1 Expand High Impact Specialty Care Capacity in most impacted medical specialties
Performing Provider: Texas Tech University Health Sciences Center – Amarillo/084563802
Unique Project ID: 084563802.1.1
Project Components: 1.9.1.a-d

Provider: Texas Tech University Health Sciences Center (TTUHSC), School of Medicine, Amarillo campus, is located in the Amarillo metropolitan area of approximately 250,000 and a service area which spans 26 counties of the Texas Panhandle. The Amarillo campus is home to the Breast Center of Excellence (BCE), following strict quality assurance guidelines to qualify as a Center of Excellence. TTUHSC-BCE Amarillo was founded in 2009 as a collaborative project between Texas Oncology Professional Associates and the North West Texas Hospital Systems when the first fellowship breast surgical oncologist was hired by TTUHSC (1 specialist / 429,191 people in TX-Panhandle). This alliance was created to provide high quality comprehensive care to breast patients of the Texas Panhandle. The Center was designed based on standards provided by the National Accreditation Program for Breast Centers (NAPBC) that espouses all NQF measures endorsed by a consortium of twenty plus national organizations incorporating multiple disciplines catering to breast care. TTUHSC-BCE is the first center accredited by the NAPBC in West Texas. TTUHSC-BCE provides multidisciplinary cancer care, dedicated benign breast services, risk assessment and prevention program, survivorship program and a robust community outreach.

Intervention: This project will enhance subspecialty training for breast disease by initiating an Interdisciplinary Breast Fellowship Program. This intervention will have both short-term and long-term advantages for the target population. In the short-term, Fellows will be able to enhance the reach of the program through training under supervision at distant geographic locations where enhanced quality care will be delivered locally. This would increase the ratio of specialist access from 1/429,191 people to 2/429,191 (an increase by 100%). In the long run, this intervention will enhance the provider pool because subspecialty physicians are likely to practice within the region of their training. This would also provide networking opportunities with local hospitals for quality improvements initiatives supported by the university.

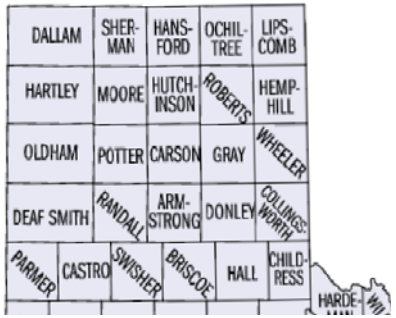
Need for the Project: Breast cancer is one of the most common cancers among women; the mortality from breast cancer in the Panhandle is higher compared with the rest of the State. This is attributable to many factors related to access and delivery of care issues that are complicated by geographical distances and financial constraints of a culturally diverse indigent population. Currently there is no Breast Fellowship Program in West Texas. TTUHSC-BCE provides specific programs for outreach and education of underserved population; the impact of this program has been documented by a decrease in diagnosis of late stage breast cancer from 20% in 2009 to 5% by the end of 2012 [Texas Pub Health Journal 2013; 65(1): 28-31.] The proposed training will provide the trainees with these specific tools that target the underserved populations and enhance quality of care and reduce the cost of cancer care.

Target population: The target population is the people of the Texas Panhandle (429,191) that seek care at the TTUHSC-BCE through facility-based or outreach-based programs. There are approximately 300 breast cancers diagnosed in this area every year and TTUHSC-BCE treats a third of these women; 54% of our women are uninsured or underinsured and the program invests specifically in system navigation and counseling which would be an essential training component of the proposed fellowship.

Category 1 Outcome: The project seeks to establish a nationally accredited subspecialty training program which would graduate 1 Fellow every year in DY 3, and DY 4 and 2 fellows in DY5. By DY5, there will be an increase in graduates accepting positions in the Texas Panhandle from a baseline of zero.

Category 3 Outcome: Our goal is to enhance the quality of breast care throughout the Texas Panhandle by creating a network of satellite centers of the TTUHSC-BCE accredited by the NAPBC thereby ensuring that all the 27 standards of breast care delivery are met by these satellite hospitals.

Project Option: 1.9.1 Expand High Impact Specialty Care Capacity in most impacted medical specialties
Performing Provider: Texas Tech University Health Sciences Center – Amarillo/084563802
Unique Project ID: 084563802.1.1
Project Components: 1.9.1.a-d
Project Description:



This project is targeting the long-term goal of enhancing specialized provider pool in the area of breast disease in the Texas panhandle. The proposed Interdisciplinary Breast Fellowship is a one-year program designed according to the requirements set forth by the Society of Surgical Oncology to meets the quality standards to be offered to physicians who have completed a residency program in general surgery or obstetrics and gynecology. This program will specifically focus on the access issues of rural healthcare delivery such that trained specialists not only provide high quality care but are particularly sensitive to the geographical and cultural issues that face the underserved populations. The main training hub for this project will be the Breast Center of Excellence at Texas Tech University Health Sciences Center in Amarillo. This approach is specifically taken to ensure quality of training. The Center director is currently the only fellowship trained provider and the center (for the entire TX-Panhandle) is the first center in West Texas to be accredited by the National Accreditation program for Breast Centers (NAPBC). Therefore the team at TTUHSC-BCE would be able to provide high quality training by virtue of its commitment to the population of the Texas panhandle; the center currently treats one-third of the panhandle's case load of breast cancer. Fifty four percent of these patients are un-insured or under insured; a large number of patients have to travel more than an hour for specialty care. Through the outreach efforts, the BCE has fostered collaborative relationships with various county hospitals. This has led to realization that these hospitals provide care to a significant number of patients that fall in to a "safety-net" group. Therefore, this is deemed an ideal set-up for sub-specialty training. The fellows will have access to a high volume of patients under supervision as they develop their skills for outreach, education, work-up of common symptoms and highly specialized cancer prevention and care. This training program will train physicians as specialists specifically targeting people with commitment to provide service to the distant communities of Texas panhandle, thus providing high quality care to patients close to home; while maintaining relationship with the university so that joint quality improvement initiatives can be undertaken. The clinical program will be completed in one-year but by DY 5; fellows will have an option of an additional research year where they could focus on research methodology and development of innovative approaches targeting rural health care delivery issues. Essentially this program will double the number of specialists for the TX-Panhandle population and provide risk assessment and prevention, multidisciplinary cancer care, benign disease, survivorship, community outreach and research training as service components. The program will monitor learning objectives of the fellows and collect feedback from the fellows for continuous improvement of training quality.

In order to achieve the training program that is accredited by the Society of Surgical Oncology the TTUHSC-BCE will enhance the training faculty by hiring an additional surgical oncologist; the program will also create collaborative partnerships with School of Pharmacy to provide research training. The program will leverage the relationship with Amarillo Area Breast Health Coalition to provide outreach training and community service by incorporating the fellow.

Target Population: The target Population for service delivery and provision of specialty services is the 26 counties of Texas panhandle (see map) [population = 429191].

The graduates from general surgery and obstetrics and gynecology residency programs will be invited from the entire country; international candidates will also be entertained; however, the program will target physicians that will likely serve in the target population. That is how the satellite

facilities will be created by the trained providers that would eventually be accredited by the NAPBC thus ensuring high quality breast care delivery for the population.

Project Goals:

The goal of this project is to provide a specialty training program in the region, such that physicians that have ties to this region can receive high quality training and possibly be recruited to serve within the region. This goal will be achieved via a step-wise strategic approach between DY2 and DY5. Specific objectives would include:

- Create a comprehensive breast fellowship curriculum encompassing all recommended elements by the Society of Surgical Oncology with a specific focus on rural health care delivery (completion of this objective would be measured with Milestone 1: P-14; metric: P-14.1by collecting the completed application to the TTUHSC- Graduate Education Committee, the Society of Surgical Oncology, Texas State Medical Board)

- Enhance faculty pool to provide adequate number of surgical and clinical exposure to the trainees (completion of this objective would be measured with Milestone 1: P-14; metric: P-14.2 by collecting documents from HR departments and faculty roster of the program documents)

- Graduate one fellow in DY3 and DY4 and 2 fellows in DY5 to enhance the specialist provider pool (completion of this objective will be measured with Milestone 3,5, and 7: P-14.1 by collecting documentation of graduation of fellows in DY3, 4 and 5).

Enhance breast specialty care delivery in the Texas panhandle by increasing the training program from a baseline of zero (completion of this objective will be measured by Milestones 2,4, and 6: I-31; metric 13.1by collecting data on the fellowship training from 0 to 1 each in DY3 and 4 and increase to 2 fellows in DY5).Enhance specialty care access for the TX-Panhandle population by increasing the specialist availability from 1 to 2 within the region (completion of this objective will be measured with Milestone 8: I-32; metric 13.2 by collecting data on the number of graduates taking positions within the TTUHSC-BCE). **This project meets the following regional goals:** According to the needs assessment cancer is identified as an urgent care need for this community (CN.6). The Amarillo BRFSS data indicated that only 62 percent of the female reported having had a mammogram. Of women 45 to 64 years of age, 15.8% have never had a mammogram. This data actually overestimates screening rates in target communities. The Breast Center of Excellence at Texas Tech Health Sciences Center (BCE) has engaged in community outreach and has reported on the limitations of this data. In addition the following map depicts the availability of breast services in the Texas Panhandle. Establishing a breast cancer fellowship and adding surgical oncologist to provide state of the art training will significantly impact and improve specialty care in the Panhandle (CN.5). It will also greatly improve outreach and education of the Panhandle providers through telemedicine as part of the fellowship and, in person, BCE provider presence in Panhandle patient care facilities. In this aspect it will impact on an important component of RHP 12's primary provider care shortage (CN.1). The breast care training will uniquely focus on challenges of rural care in an underserved population. The BCE has always been available to all patients regardless of ability to pay which also addresses patients who are denied or have delayed care because they have no medical insurance (CN.3).

Challenges:

The biggest challenge is that there are currently no breast fellowship programs available in West Texas. Interested residents therefore seek training in metropolitan cities elsewhere and are likely to stay in the region of training. Moreover, whereas the training in the metropolitan cities have an excellent focus on specialty care, they typically do not address the issue of healthcare access or training on particular aspects of rural healthcare delivery systems that might be quite different from their local realities. West Texas presents a peculiar situation with vast geographical distances occupied by socio-economically underserved and largely culturally diverse population. Training programs in this area need innovative designs that not only emphasize the high quality technical care but also address the issues of delivery of this care to this very unique population.

Breast cancer is one of the most common cancers, and one of the most common cause of deaths among women. Moreover, there are a huge number of benign conditions of the breast that require adequate work-up, treatment and specialty care. At this point, there is only one fellowship trained breast specialist in the Texas-Panhandle. There are approximately 300 new breast cancer diagnosed in Panhandle per year; there are approximately 5,000 survivors in this region and approximately 1,500 specialty appointments occur per year for benign conditions. The challenge is to design training programs that target committed physicians to deliver high quality breast care in this area.

5-Year Expected Outcome from Provider and Patients:

The five year expected outcome is to have satellite facilities in the TX-panhandle that are led by graduates of the TTUHSC-BCE fellowship such that those facilities are accredited by the National Accreditation Program for Breast Centers (NAPBC) just like the current status that the TTUHSC-BCE holds. This would cater to the regional goal of enhancing quality of cancer care, increasing the number of specialists performing these services in the region, and allowing patients access to high quality breast care close to home. In addition, this would foster free flow of data to measure quality of care and therefore foster joint quality initiatives.

Starting Point/ Baseline:

There is no Breast fellowship program available in West Texas; there is only one fellowship trained surgeon in the region. Two-thirds of breast cancer treatment is provided by non-specialty trained physicians.

Rationale:

According to the needs assessment report, cancer is one of leading causes of death in Texas; specifically, focusing on the Texas panhandle, Breast cancer is one of the commonest cancers in the region and whereas the incidence rate is the same as rest of the state, the mortality is higher in the Texas panhandle (http://www.dshs.state.tx.us). TTUHSC-BCE has analyzed it's data and the Goldston Tumor Registry data that reveals that the high mortality is potentially related to delay in diagnosis and presentation at higher stage. That is why TTUHSC-BCE has planned an initiative to address this devastating illness by enhancing work-force that is uniquely trained for this area. Another important rationale behind the choice of breast cancer specialty for training is the fact that by sheer virtue of sheer volume of cases, and the already existing center of excellence, this provides an ideal scaffolding for building further training programs in other areas. Therefore this program should be scalable to address outreach issues with other cancers such as cervix and colorectal.

Project Components:

a) Identify high impact / most impacted specialty services and gaps in care and coordination

b) Increase the number of trainees choosing targeted shortage specialties

c) Design work force enhancements initiatives to support access to specialty providers in underserved areas

d) Identification of opportunities to scale relevant parts of project to a broader patient population specifically the "safety-net" population

This project is specifically designed to address all the core components: First, focus groups and outreach efforts are continually conducted to identify the need for breast specialty care in the community. The stakeholders from county hospitals are involved in this assessment. Second, the program has enough volume and resources to train one fellow per year; considering the fact many remote areas have gynecologists performing breast care, this program is specifically designed to include graduates form obstetrics and gynecology residency; this option is not readily available to gynecologists with other programs in the country. TTUHSC-Amarillo has a robust obstetrics/gynecology residency program; the residents rotate through breast program;

this will allow enhance the graduates choosing the fellowship training. Third, the program will work closely with the regional hospitals to enhance recruitment and retention of the fellowship graduates within the region. Lastly, the program will maintain close ties with its graduates to jointly conduct quality improvements initiatives with a goal to enhance the level of care at regional hospitals to meet the national standards endorsed by the NAPBC as satellites of the already accredited program. The program director is also the medical director for the Breast and Cervical Cancer Screening (BCCS) Program. This would be leveraged to ensure that the safety-net population is targeted.

The process milestones chosen were "development of training curriculum and documentation of support for the program". This is planned to allow monitoring of steps towards producing a highly qualified work force that would deliver specialty care in the Panhandle. The improvement measure 31 would also track the output of the program to track how these trained specialists are being hired and retained in the TX-Panhandle to impact the clinical outcome for the target population. This would allow uniform care delivery across the Panhandle in the long-term and graduates of the program would provide free and transparent data reporting for quality initiatives and monitoring. Both these measures are geared toward the ultimate goal of improving delivery of high quality of care. Importantly, P11 is included to promote collaborative learning such that best practices that are scalable can be developed for replication.

Unique community need identification numbers the project addresses:

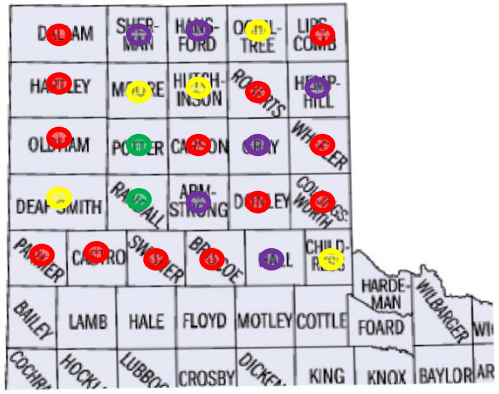
CN.6 - (Community Identification Number -CN.6). According the needs assessment report, cancer area is identified as the urgent care need for this community. The Amarillo BRFSS data indicated 62.0 percent of the female respondents reported having had a mammogram. Of women age 45 to 64, 15.8% has never has a mammogram. This data actually overestimates screening rates in the target counties; TTUHSC-BCE has been engaged in community outreach and has reported on the limitations of this data[1]. In addition, the following map depicts the availability of services in the TX-Panhandle.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

This represents a new initiative not only because there is no fellowship training program available for breast health in West Texas but also because it is specifically designed to address the healthcare delivery issues of rural populations that are geographically distant and culturally diverse. The program team has had a long-term partnership with community stakeholders including small hospitals, lay public and influential members of the community to develop culturally sensitive methodology for this training. Specifically, partnership with Hispanic Chamber of Commerce has been leveraged to incorporate culturally appropriate methods for outreach training and engagement of socially isolated populations. Out of the 33 breast fellowship programs, none offer this specific training component despite their outreach component.

<u>Related Category 3 Outcome Measures:</u>

OD-9 Right Care, Right Setting



Adequate Screening and Prevention Program Available

Adequate Screening and No Prevention Program Available

Inadequate Screening and No Prevention Program Available

No Screening or Prevention Program Available

IT-9.4 The improvement target chosen is a stand-alone measure targeting the "right care" since the ultimate goal is to enhance delivery of high quality breast care to the population of the TX-Panhandle. The quality measures for the specialty of breast disease (both

benign and malignant) are standardized by the National Accreditation for Breast Centers (NAPBC). Numerator: The number of patients receiving care according to the standard of care determined by NAPBC (utilizes NQF measures). Denominator: All patients presenting with breast disease. The process milestone number 14 is chosen to track the development of the specialty training program; improvement measure 31 would track the number of trainees produced by the program that feed into the main of improving quality of care delivery in the TX-Panhandle.

Reasons/rationale for selecting the outcome measures:

The specific rationale for choosing this measure is to focus on ultimate national quality forum (NDF) measures. NAPBC is a national quality care program formed through a consortium of national professional organizations focused on breast health and dedicated to the improvement of quality care and outcomes of patients with diseases of the breast through evidence-based standards and patient and professional education[2]. The NAPBC has put forth 27 standards including competence, NQF measures of clinical outcome and continuing education to be achieved for accreditation. Therefore, the stand-alone measure chosen for all the TTUHSC projects is the percentage of patients with breast disease receiving standard of care as defined by the NAPBC. The goal is to deliver high quality standard of breast care to 50% of patients with breast disease by the end of the waiver.

Relationship to other Projects:

TTUHSC-BCE is a unique project which, when launched, will facilitate the enhancement of specialty care and strengthen the university-community partnership. This will in turn give rise to the success of other collaborative projects.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

Criteria	***Narrative***	***Score***
Achieves Waiver Goals	*The Interdisciplinary Breast Fellowship program fully addresses the Triple Aim of assuring that patients receive high-quality, patient-centered care in the most cost effective ways. With the rapid advancement in the field of breast disease, specifically breast cancer, the provision of high quality care demands specialists trained with specific focus, new and updated information and skill-set. Well-trained individuals can provide individualized patient-centered treatment options with the newest and most cost effective modalities. The Texas Panhandle has approximately 300 new breast cancers a year with a significant number of patients presenting at advanced stage. Outreach training of specialists would help promote preventive practices and increase survival in the region over the long-term.*	***5***
Addresses Community Need(s)	*The project targets the area of cancer care identified as "Urgent" in the Community Needs Assessment (CN 6); TTUHSC-BCE is heavily engaged in preventive work and screening of underserved population of Panhandle. 54% of our patients are underinsured. Producing highly qualified subspecialists with a program that emphasizes on best practices for indigent care will address a dire community need.*	***4***
Project Scope/Size	*This project is the very significant in terms of its reach of the TX-Panhandle community. These benefits will be long-term but long-lasting. Program graduates will not only serve the community during training but will be exposed to active recruitment and retention campaign which will vastly impact the isolated communities in the region.*	***5***
Project Investment	*The main expense of this project is the salary-line for the fellow and faculty recruitment. There are other programmatic costs expected in terms of faculty recruitment for training enhancement and exposure and contractual obligations from multidisciplinary training rotations.*	***4***

084563802.1.1	*1.9.1*	*1.9.1.A-D*	**Expand High Impact Specialty Care Capacity in most impacted medical specialties**
Texas Tech University Health Science Center – Amarillo			***084563802***
Related Category 3 Outcome Measure(s):	***084563802.3.1***	***IT – 9.4***	***Other Outcome Improvement Target***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-14 Expand Targeted Specialty Care (TSC) training Metric(s): P-14.1 14.1a. Documentation of applications and agreement to expand training programs 14.1b.Data Source: TTUHSC - GME and Texas State Medical Board Metric(s): P-14.2 14.2a. Number of additional faculty/staff members 14.2b. Data Source: HR documents Baseline/Goal: 0 programs for specialty training/Establishment of curriculum/program for trial approved by TSMB Milestone 1 Estimated Incentive Payment: $432,940	Milestone 3: [RHP PP Milestone - P-14]: Expand Targeted Specialty Care (TSC) training Metric(s): [RHP PP Metric - P-14.1] a. Documentation of applications and agreement to expand training programs Baseline/Goal: 1 fellow b.Data Source: TTUHSC – accreditation application to the Society of Surgical Oncology Milestone 3 Estimated Incentive Payment: $451,650	Milestone 5: [RHP PP Milestone - P-14]: Expand Targeted Specialty Care (TSC) training Metric(s): [RHP PP Metric - P-14.1] a. Documentation of applications and agreement to expand training programs b. Expansion to incorporate translational research curriculum Baseline/Goal: 1 fellow b.Data Source: TTUHSC - GME and Texas State Medical Board approval documents Milestone 5 Estimated Incentive Payment: $483,161	Milestone 7: [RHP PP Milestone - P-14]: Expand Targeted Specialty Care (TSC) training Metric(s): [RHP PP Metric - P-14.1] a. Documentation of applications and agreement to expand training programs Baseline/Goal: 2 fellows b.Data Source: TTUHSC - accreditation document from the Society of Surgical Oncology Milestone 7 Estimated Incentive Payment: $466,822
Milestone 2: I-31 Increase TSC training Metric(s): I-31.1 Increase in the number of fellowship programs	Milestone 4: [RHP PP Milestone - I-31]: Increase TSC training Metric(s): [RHP PP Milestone - I-31.1] Increase the number of TSC trainees at TTUHSC-Breast Center of	Milestone 6: [RHP PP Milestone - I-31]: Increase TSC training Metric(s): [RHP PP Milestone - I-31.4] Increase the number of TSC trainees	Milestone 8: [RHP PP Milestone - I-32]: Percent change in number of graduates to TSC positions at TTUHSC Metric(s): [RHP PP Milestone - I-

084563802.1.1	*1.9.1*	*1.9.1.A-D*	**Expand High Impact Specialty Care Capacity in most impacted medical specialties**
Texas Tech University Health Science Center – Amarillo			***084563802***
Related Category 3 Outcome Measure(s):	***084563802.3.1***	***IT – 9.4***	***Other Outcome Improvement Target***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: 0 Data Source: TTUHSC - GME and Texas State Medical Board Milestone 2 Estimated Incentive Payment: $432,939	Excellence-Amarillo Baseline/Goal: 0 Data Source: TTUHSC - GME Office Milestone 4 Estimated Incentive Payment: $451,650	over baseline (double) i.e. 2 fellows per year Baseline/Goal: 0 Data Source: TTUHSC - GME Office Milestone 6 Estimated Incentive Payment: $483,160	32.1] Percent change in number of graduates accepting positions Baseline/Goal: 0 Data Source: HR documents and GME office Milestone 8 Estimated Incentive Payment: $466,821
DY 2 Estimated Milestone Bundle Amount: $865,879	**DY 3 Estimated Milestone Bundle Amount: $903,300**	**DY4 Estimated Milestone Bundle Amount: $966,321**	**DY5 Estimated Milestone Bundle Amount $933,643**
Estimated DSRIP Funding for Years 2-5: $3,669,142			

Project Option: 1.2.4 Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)
Performing Provider: Texas Tech University Health Sciences Center – Amarillo/084563802

Unique Project ID: 084563802.1.2

Provider: Texas Tech University Health Sciences Center at Amarillo - Department of Family and Community Medicine (FM) is made up of 8 faculty physicians, 3 non-physician practitioners, and 19 resident physicians. Combined, these practitioners serve more than 28,000 patients annually. Approximately 30% of those patients are on Medicaid, 25% are on Medicare, and another 7% are uninsured. All of these patient types benefit greatly from the expansion of the Family Medicine Accelerated Track (FMAT) training program, and the expansion of the family medicine residency-training program in Amarillo.

Intervention: The department will add up to 2 family medicine residency positions per year, increasing the total number of family physicians in training up to 6 over current levels once the program is fully implemented, and will implement required rural experiences in Pampa, Texas (HPSA ID#148179). To facilitate the expansion of the FMAT program and the residency program, the department will add 2 family physician faculty positions as well.

Need for the project: There is a major shortage of primary care physicians in the U.S. and in Texas, which is more pronounced in the Panhandle, especially in rural communities, areas where family physicians provide the vast majority of medical care. Physicians are much more likely to practice near the areas where they receive their residency training, and are more likely to practice in rural communities if they are exposed to those areas in their training programs. The FMAT program is a national model to prepare fully trained family physicians at lower cost and in a shorter timeline than traditional training models. This project not only directly expands services to Medicaid patients in our area, but prepares more of the physicians most likely to practice in the areas of greatest need in Texas, and to provide preventive and chronic disease management services that dramatically lower healthcare costs.

Target population: Our project targets everyone in need of primary care services in the Texas Panhandle, by directly increasing services, and by training more primary care physicians to serve the continued needs of our region and our state. Currently, approximately 40% of our patient population are on Medicaid or are uninsured.

Outcomes: This Category-1 project's milestones are designed to produce and introduce increasing numbers of qualified family medicine practitioners into communities in a shorter, more concentrated training fashion, and to provide opportunities to learn in a more underserved rural setting. This is a multi-layered intervention that will serve the Medicaid and uninsured population in Amarillo and the surrounding communities, while increasing rural training and services, and enhancing access to the right care, in the right place, at the right time for tens of thousands of Texans. As with the Category-1 milestones and metrics, while not totally developed, this project's Category-3 outcomes will seek to directly address the most significant need in, and challenge of RHP12, as indicated in the region's community needs assessment: The severity of the shortage of primary care providers and increasing demand for family medicine access to care.

Project Option: 1.2.4 Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)

Performing Provider: Texas Tech University Health Sciences Center – Amarillo/084563802

Unique Project ID: 084563802.1.2

Project Description: In the face of insistent calls for an expanded primary care workforce, we propose the Texas Tech Primary Care Training Innovation Initiative- Amarillo (PCTII Amarillo), a true innovation in health care education. The PICTII Amarillo program aims work closely with the PCTII initiative developed for TTUHSC in Lubbock to re-balance of the Texas physician workforce in favor of primary care through expanded primary care training programs, all with a primary locus within HPSAs.

Project Goals: This Infrastructure Development/ Increase Training of Primary Care Workforce Project will increase training of the primary care physician workforce through the following project goals:

- To strengthen and sustain Amarillo-based activities of the Family Medicine Accelerated Track (FMAT), an innovative three-year accelerated medical school curriculum at the Texas Tech University Health Sciences Center (TTUHSC) School of Medicine; the FMAT program increases primary care capacity and expands the primary care workforce by producing family physicians more quickly and at less cost.

- To develop new family medicine residency positions in Amarillo available to provide post-graduate training and thus accommodate additional medical students entering the family medicine/ primary care workforce.

Project Outcomes: The PCTII program's broad outcomes are to increase expand or establish primary care training programs and thus improve future health care capacity in Texas. Specific PCTII outcomes include:

Family Medicine Accelerated Track

- A full complement of Amarillo-based faculty available for the teaching programs involved with the FMAT program, at both pre-doctoral and residency levels, with the addition of 2 faculty FTE in the Department of Family and Community Medicine.

- Sustained scholarship support for FMAT pre-doctoral students, with the establishment of a scholarship fund for students enrolled in the FMAT program; these scholarships are integral in the reduction of student debt and hence a barrier to primary care specialty selection

- An effective and operational curriculum, with assessment tools and program metrics, available to all Texas medical schools and training sites; this curriculum will include a new series of curricular experiences that will assist learners in systems-based practice that leads to lower health care costs through improvement in decision-making, system efficiencies and coordination of resources

Family Medicine Residency Program Expansion

- Adequate family medicine residency positions in Amarillo, including rural training rotations, with an emphasis in communities designated as HPSAs, to accommodate up to 9 family medicine positions in each of three training years.
- Support for family medicine residency position salary and benefits, as well as to recruit additional residents.
- A set of curricular experiences in the Family Medicine residency program that focus on the medical home model and that highlight residents' continuity of care for their panel of patients

Challenges and Issues: At the outset of the FMAT program, we anticipated what might be considered "standard" challenges to implementing an ambitious curricular initiative: resistance to change among faculty and students, finding time and resources, reconciling differences among proposed strategies and disparate departments that may view one another as competitors for students and residents. Based on our experience with the FMAT program thus far, the goals proposed by this project are designed to address the challenges that we have indeed faced: the need for additional faculty, student support, curricular resources and residency training opportunities. This is especially acute in a program such as FMAT that has been developed across multiple campuses. The development of new residency training positions is not without its challenges—new or expanded programs must meet ACGME and Review Committee guidelines, and approval/ accreditation must follow carefully defined procedures. Nonetheless, TTUHSC's Family Medicine residency program in Amarillo recently received 5 years' reaccreditation.

Starting Point/Baseline: As of September 2012, the TTUHSC FMAT school-wide program has nine students in the first class (FMATc2013); these students have completed two years of medical school and the first two FMAT-specific courses. All of these students passed the USMLE Step 1 exam (taken in June 2012), a key milestone in the assessment of student and program effectiveness. These students will graduate and enter residency training in the summer of 2013. The seven students in FMATc2014 have completed their first year of medical school and the FMAT1 summer enrichment experiences; they began a longitudinal family medicine clerkship on August 8, 2012. Additionally, as of February 2013, the FMATc2015 has 8 students who will begin their FMAT coursework in June 2013.

For this 1.2.4 PCTII Project, we will expand the residency slots in the Amarillo Family Medicine Residency Program to support up to 2 additional resident positions in each of three training years. The Family Medicine residency program in Amarillo has 7 positions per year. The Amarillo program does not

currently provide its residents with defined rural rotations, such as in health professions shortage areas. Thus, one deficit to be addressed by the PCTII program will be the development of a rural rotation in Pampa, Texas, 54 miles to the northeast of Amarillo (HPSA ID #148179). Resources from this Project will also cover residents' salary and benefits, recruitment costs, and other expenses related to residency expansion, such as for office space, lab coats, continuing medical education, travel between Amarillo and Pampa as the rural residency training site, and so forth. This Project will also drive development of a set of curricular experiences in the Family Medicine residency program that focus on the medical home model and that highlight residents' continuity of care for their panel of patients. This curriculum will be delivered through both didactic and experiential modes for all residents in the Amarillo Family Medicine program.

Rationale: Current and prospective shortages in the primary care physician workforce are well documented, especially in Texas. Although physician capacity among specialists has kept up with the overall population growth in Texas, primary care physician capacity has not. Nor have the number of entry-level primary care residency slots kept pace with the growth in Texas medical school enrollment. The PCTII-Amarillo project will address these shortages at both the undergraduate and graduate medical educational levels. It will also use innovative curricular modalities and positive primary care exposure--significantly, exposure within a setting that itself will expand primary care access to an undeserved population.

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. The most common explanation for shortages in the primary care physician workforce is financial, related both to student debt loads (which have increased dramatically in recent years) and to the disparity in compensation between primary care and subspecialty physicians, issues specifically addressed by the FMAT program.

Although the number of Texas medical graduates is expected to peak in 2015, the number of available graduate medical education (GME) positions have not kept pace, and the Texas Higher Education Coordinating Board predicts a shortage of 400 GME positions. The shortage of GME positions or residency slots maybe the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage. Thus, the addition of family medicine positions at TTUHSC will address both the GME shortage and the need for additional primary care physicians.

Community Need Rationale and Identifier: Within RHP12, the primary care provider shortages are especially acute. The specific RHP community need that this project addresses is CN.1--Severe primary care provider shortage, wait time, expense, lack of insurance, & access to care. This project selection has no required "core components." This project does represent a significant enhancement to existing but newly developed healthcare workforce training initiatives – the TTUHSC FMAT program and new family medicine residency positions. Each of the milestones and metrics are reflective and relative for the objective of this initiative and add directly to the desired outcome. It is expected that this project will provide sustainable year-over-year benefit to the region and State of Texas long beyond the initial Texas 1115 Waiver demonstration years.

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: N/A

Relationship to Other Performing Providers' Projects in the RHP and plan for Learning Collaborative : Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects. This initiative is linked to the PCTII project developed for Lubbock, which shares a focus on the FMAT program and additional residency positions (084599202.1.1).

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Relative to other proposed projects presented by TTUHSC-Lubbock, this project will improve the workforce and healthcare infrastructure of RHP12 to better serve the Medicaid, uninsured, and underinsured patient base of West Texas because of its emphasis and clinical rotation sites, many within federally designated primary care HPSAs. The regional exposure of these clinical rotations frequently provide for a number of medical graduates to set their practice up in these more rural & frontier areas of the region. This project will ultimately address the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways while simultaneously providing for a heightened sensitivity to providing care to patients in underserved areas. Texas Tech Physicians of Amarillo is a 91-physician group that provides over 163,000 patient encounters per year to the Panhandle region of Texas.	**4**
Addresses Community Need(s)	As identified in the project description: In the face of insistent calls for an expanded primary care workforce, we propose a true innovation in health care: a re-balance of the Texas physician workforce in favor of primary care by proposing a project that will establish or expand primary care training programs, all with a primary locus within HPSAs. This project will specifically address, what is considered one of the most critical of RHP12's and the State's community needs: C.1 - the severe primary care provider shortage, wait time, expense, lack of insurance, and access to care. While it may not address but one specifically for the region, it clearly is addressing one of two needs deemed and classified as "most critical" for the region. We believe this project will definitely "move the dial" by graduating family practice-focused medical professions, in greater numbers, at a reduced cost, and in shorter time frames.	**5**
Project Scope/Size	Medium immediate scope, but this project will have vast impact and positive influence over the healthcare workforce and structure of this region over the long term. This is a building process that will generate and regenerate positive output for many years after the initial startup. From September 2011 – August 2012, Texas Tech Physicians of Amarillo, Department of Family and Community Medicine provided healthcare services through 34,691 total patient encounters, of which more than 33% were Medicaid/Uninsured patients. That percentage is increasing as the number of willing Medicaid providers decreases relative to growth in the Medicaid program. Currently, 47% of our total patient visits are Medicaid/Uninsured patients. Each family medicine resident must see a minimum of 1650 continuity patients during their three years of residency. Our faculty members typically see an additional 1000 continuity visits each per year. Thus, the addition of 2 faculty and up to 6 residents will add more than 5000 patient visits per year.	**3**
Project Investment	This project will require a relatively large investment, especially in human resources, time for fully develop and expand, and development of organizational priorities within the project itself.	**4**

084563802.1.2	***1.2.4***	***N/A***	***Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)***
Texas Tech University Health Sciences Center - Amarillo			*084563802*
Related Category 3 Outcome Measure(s): TBD	***084563802.3.2***	***TBD***	*Treatment Preferences TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Expand Primary care training for primary care physicians Metric 1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: An increase of 1 FTE in the number of faculty to support expanding training program. Data Source: HR documents, faculty lists, or other documentation Metric 2 [P-2.3]: Develop alternative primary care training modalities, including a 3-year accelerated medical curriculum. Goal: To offer a more focused and interactive education training modality and experience Data Source: Training Program Documentation	**Milestone 3 [**P-2]: Expand Primary care training for primary care physicians Metric 1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: An increase of 1 FTE in the number of faculty to support expanding training program. Data Source: HR documents, faculty lists, or other documentation **Milestone 3 [P-2] Estimated Incentive Payment***:* $ 632,672 **Milestone 4** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents Metric 1 [P-10.1]: Submit application	**Milestone 6** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees by up to 2 in each residency class over DY 2 numbers Goal: To increase the number of primary care residents Data Source: Program enrollment records Milestone 6 [I-11] Estimated Incentive Payment *(maximum amount):* $ 470,707	**Milestone 7** [P-2]: Expand primary care training for primary care physicians Metric 1 [P-2.1]: Expand the primary care residency training programs and/or rotations Goal: An increase of up to 2 family medicine residency positions per training year Data Source: Training Program Documentation applications and agreements to expand. **Milestone 7 [P-2] Estimated Incentive Payment:$** 470,708 **Milestone 8** [I-13]: Increase the number/proportion of primary care residency/trainee graduates

084563802.1.2	***1.2.4***	***N/A***	***Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)***
Texas Tech University Health Sciences Center - Amarillo			*084563802*
Related Category 3 Outcome Measure(s): TBD	***084563802.3.2***	***TBD***	*Treatment Preferences TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2] Estimated Incentive Payment*:* $ 632,672 **Milestone 2 [P-3]:** Expand positive primary care exposure for residents/trainees (must include at least one of the following metrics). Metric 1 [P-3.1]: Develop mentoring program with primary care faculty and new trainees Goal: Foster primary care trainees' interest in pursuing primary care careers. Data Source: Mentoring program curriculum and/or program participant list Metric 2 [P-3.2]: Train trainees in the medical home model; have primary care trainees participate in medical homes by engaging panels Goal: To expose trainees' to evolving	for ACGME approval for residency position expansion Goal: To increase the number of primary care residents in an effort to increase patient access to care for all, including Medicaid. Data Source: Submitted application including evidence justifying the number of residents needed Milestone 4 [P-10] Estimated Incentive Payment *(maximum amount):* $ 470,708 **Milestone 5** [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites Metric 1 [P-9.1]: Submit clinical teaching tools Goal: Published comprehensive curriculum and evaluation plan for a 3-year family medicine accelerated track Data Source: Enlist institutions that		choosing primary care as a career Metric 1 [I-13.1]: Number of primary care residency/trainee graduates working in primary care settings. Goal: Continuing high numbers of family medicine residents continuing to practice primary care and an increase in the number of overall graduates in primary care practices Data Source: Program and follow survey documentation **Milestone 8 [I-13] Estimated Incentive Payment***:* $ 1,364,370

084563802.1.2	***1.2.4***	***N/A***	***Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)***
Texas Tech University Health Sciences Center - Amarillo			*084563802*
Related Category 3 Outcome Measure(s): TBD	***084563802.3.2***	***TBD***	*Treatment Preferences TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
primary care delivery models. Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee Milestone 2 [P-3] Estimated Incentive Payment *(maximum amount):* $ 632,672	provide clinical teaching as consultants. **Milestone 5 [P-9] Estimated Incentive Payment***:* $ 660,014		
Year 2 Estimated Milestone Bundle Amount: $769,670	Year 3 Estimated Milestone Bundle Amount: $802,933	Year 4 Estimated Milestone Bundle Amount: $858,952	Year 5 Estimated Milestone Bundle Amount: $829,905
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $3,261,459			

Project Option: 1.9.2 Improve access to specialty care
Performing Provider: Texas Tech University Health Sciences Center – Amarillo/084563802

Unique Project ID: 084563802.1.3 – **"PASS 2"**

Project Components: 1.9.2.a-d

- **Provider:** Texas Tech University Health Sciences Center-Amarillo, Department of Pediatrics, is the largest provider of pediatric Medicaid services in the northern Texas Panhandle. We serve an immediate community of approximately 250,000 in the Amarillo metropolitan area. Additionally, we serve as the primary referral center for pediatric services in the northern 26 counties of the Texas Panhandle. Our pediatric clinic performs approximately 40,000 clinical encounters per year, 75% of which are to financially disadvantaged children.

- **Intervention(s):** This project will bring pediatric endocrinology and pediatric urology services for financially disadvantaged children into our community.

- **Need for the project:** There are currently no pediatric endocrinologists in the northern Texas Panhandle. This is in spite of a relatively large catchment area and a burgeoning rate of type 2 diabetes mellitus in children. There is currently one urologist in Amarillo who is willing to seek children with Medicaid funding. This physician limits his Medicaid practice in order to maintain financial viability. Children who are unable to be seen locally require transport to Dallas or Lubbock (2-5 hours away).

- **Target population:** Our target population is children requiring endocrinology or urology consultation or management services in the northern 26 counties of the Texas panhandle. Currently 75% of our patient population either have Medicaid funding or are indigent.

- **Category 1 expected patient benefits:** The project seeks to Provide 500 endocrinology or urology patient encounters in DY3, 1000 in DY 4 and increase to 1100 in DY 5.

- **Category 3 outcomes:** IT-6.1 Our goal is to improve patient satisfaction with clinical services provided as measured by "Visit Survey 2.0" tool for children from CAHPS by 10% year DY5 over baseline determined in DY3.

Project Option: 1.9.2 Improve access to specialty care

Performing Provider: Texas Tech University Health Sciences Center – Amarillo/084563802

Unique Project ID: 084563802.1.3 – **"PASS 2"**

Project Components: 1.9.2.a-d

Project Description:

The goal of this project is to increase the capacity to provide specialty care services and the availability of targeted specialty providers. This will better accommodate the high demand for specialty care services in order that patients have increased access. Specialty service access is a key component of a robust healthcare infrastructure. Access to specialty care in our area is limited by geographical distances and lack of insurance acceptance. Although the vast majority of children in our area have some form of insurance, government sponsored insurance programs are not accepted by some community physicians. Specifically in pediatrics, specialist availability is complicated by our community size, where there is a significant need for one specialist, but the needs of the community may not be able to support 2 specialists of the same ilk. Difficulties then arise in providing call coverage for the provider. In the absence of available specialists, patients must travel to Lubbock (110 miles) or further to identify a specialist who can see them. This obvious changes a 30 minute clinic visit into a full day that the parent has to take off work, leading to additional financial strain on the family. We currently have no pediatric endocrinologists in our community, yet the availability of specialists to care for individuals with diabetes (endocrinologists) is listed as a severe community need in our regional community needs assessment (CN .5). Most urologists in our community either choose not to see children or severely limit the number of unfunded patients or patients with Medicaid who they see in clinic due to financial constraints. The historic "work-around" is that patients are typically referred to the Emergency Department where they are seen by the urologist on call for the hospital, or they are transported to a larger community where an endocrinologist is available. We propose to hire a pediatric endocrinologist and part time urologist to care for the needs of children in our community regardless of insurance type. We have identified a urologist with interest in pediatrics who would be willing to dedicate part of his time to the management of urologic issues in children regardless of insurance status. He has previously had to limit his Medicaid capacity because of financial concerns. The addition of this individual to our medical staff will improve access to care for Medicaid patients. There is currently no pediatric endocrinologist in our community of 200,000. Patients are currently cared for by non-specialists or referred to other cities for endocrine issues. We have already identified 400 patients with type 1 diabetes in our own clinic that would typically be seen by an endocrinologist if one was available. Obesity is a major health burden in our community. With the increase in obesity, we see an increase in rates of type 2 diabetes and hyperlipidemia in children. Historically, these are adult-onset diseases and pediatricians may not feel comfortable caring for these issues. Not only would a pediatric endocrinologist be able to assist with the direct care of some of these patients, but the education of referring physicians working alongside a pediatric endocrinologist would improve the overall quality of care of these diseases throughout our community. We anticipate overcoming the challenge of finding care for the solo endocrinologist by collaborating with endocrine colleagues in Lubbock. We have already overcome the challenge of call coverage for our urologist by garnering the agreement of his current partners to continue to share call coverage

when he transitions to this new role. By year 5 of the demonstration project we will have improved the quality and accessibility of care for children with endocrinologic and urologic issues in our community.

Project Goals

- Increase targeted specialist service availability
- Increase number of specialty clinic locations
- Implement transparent, standardized referrals across the system
- Conduct quality improvement for project using methods such as rapid cycle improvement.

This project meets the following regional goals:

- Develops a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Region 12's goal is to fulfill as many of the identified regional community needs as possible. This project will help accomplish this by fulfilling two of the identified community needs:

  CN.3 Poor insurance support or uninsured

  CN.5 Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to urban areas for care is difficult.

The goal of this project is to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services. We will specifically accomplish this by recruiting at least one pediatric endocrinologist and a urologist for pediatric patients.

Challenges:

The foremost challenge in performing this project is identifying and recruiting specialist physicians to our community. We have been actively searching for a pediatric endocrinologist and have already located a urologist with pediatric expertise. An additional challenge unique to a community our size is arranging call coverage for specialties that might not be otherwise represented in our community. We anticipate providing call coverage for our endocrinologist by working with other pediatric endocrinologists in Lubbock to develop a mutually supportive system. Our interested urologist has already discussed call coverage with his current partners, who have expressed willingness to participate.

5-Year Expected Outcome for Provider and Patients:

By year 5 of the demonstration project we will have improved the quality and accessibility of care for children in our community with endocrine and urologic issues. We will have recruited the targeted specialties and enlarged the number of patient visits each consecutive year after clinics are established.

Starting Point/Baseline:

No pediatric endocrinologists and no urologists in the TTUHSC, Amarillo system.

Rationale:

The reason we selected this project is due to inadequate access to specialty care that has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed. This project will specifically address community health needs CN.3 (Poor insurance support or uninsured) and CN.5 (Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease).

The rationale for selection of individual milestones is as follows:

P-1. Milestone: Conduct specialty care gap assessment based on community need

Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access

P-11. Milestone: Launch/expand specialty care clinics

Rationale/Evidence: Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. Additionally, specialty care clinics allow for enhanced care coordination for those patients requiring intensive specialty services.

P-20. Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions

Rationale/Evidence: The rate of testing of new solutions and ideas is one of the greatest predictors of the success of a health care system's improvement efforts.

P-6. Milestone: Develop and implement standardized referral and work-up guidelines

Rationale/Evidence: More standardized and extensive pre-visit workups and referral guidelines will help to ensure that (1) patients must meet a common criteria to require a specialty care visit (versus receiving

treatment in the primary care setting); (2) patients are triaged by urgency/need to increase specialty care access to those who need it most; and (3) the work required prior to the visit is performed before the visit is scheduled, eliminating the occurrence of multiple, initial specialist visits

I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services

Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.

Project Components:

- Increase targeted specialist service availability by adding specialty providers
- Increase number of specialty clinic locations by adding two specialty clinics to the Amarillo medical community
- Implement transparent, standardized referrals across the system with access now being available in the Northern Texas Panhandle
- Conduct quality improvement for project using methods such as rapid cycle improvement with skilled specialty providers in order to achieve improvements in healthcare delivery

Unique community need identification numbers the project addresses:

CN.3 Poor insurance support or uninsured

CN.5 Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to urban areas for care is difficult.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

There are currently no pediatric endocrinologists in the Northern Texas Panhandle. Endocrine care is delivered by non-specialists or is achieved by transferring care of patients to larger urban areas. Likewise, no urologists in our community are currently accepting unrestricted Medicaid referrals. The addition of these two specialties to our Medicaid community fundamentally changes the ease of access by our economically disadvantaged patients.

Related Category 3 Outcome Measures:

OD 6: Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains targeted for improvement utilizing the CAHPS-PCMH survey set for children.

The delivery of modern healthcare is complex, with many potential process metrics to assess quality. It is intuitive that patients will gravitate to a healthcare delivery setting that is easily accessible, timely, and of high quality. For patients to routinely access medical care in the appropriate setting by the appropriate provider, though, they must *perceive* the care they receive in that setting is accessible, timely, and of high quality. If we can make the patient's medical home the best perceived healthcare delivery setting, we can potentially reduce visits to less appropriate healthcare settings such as emergency departments. Individual process metrics may not accurately reflect the global perception a patient has of the healthcare they receive. Inclusion of a patient satisfaction survey tool allows us to measure and potentially improve that perception. Continued monitoring and response to patient satisfaction scores will assist in meeting that need. The "Visit Survey 2.0" tool for children from CAHPS will be the chosen survey tool.

Reasons/rationale for selecting the outcome measures:

The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on clinical care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Relationship to other Projects:

084563802.2.1 – Development of a Patient Centered Medical Home

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Project 084563802.2.1 (development of a patient centered medical home) also addresses Patient Satisfaction (OD 6) as a Category 3 measure. Systems improvement and lessons learned between by implementation of one project can be adapted to the other project as well. It is hoped that this collaborative effort will result in better outcomes than either project being performed in isolation. In addition to sharing the same category 3 project, the PCMH is an ideal platform to introduce improvements in referral systems and guidelines to the sub-specialties of interest.

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Achieves Waiver Goals:
Provision of needed specialty care to economically disadvantaged children directly relates to Waiver goals. Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. The development of new specialty clinics is multi-year transformational efforts. Availability of some specialty care in our community is currently limited by provider availability. Improving access to specialty care will improve convenience of care and decrease direct cost to Medicaid by decreasing transportation reimbursement costs. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. Access to specialty care was defined as a severe issue in our community CN.5. This project directly addresses that issue. As 75% of our patient population is economically disadvantaged, the population affected is the population intended by the initial waiver. **SCORE 4**

Addresses Community Needs:
Access to specialty care has been identified as a severe need in our region (CN.5). This project specifically addresses that need by improving pediatric endocrinology and pediatric urology service access. **SCORE 4**

Project Scope/Size:
This project will add two specialty clinics to the Amarillo medical community. The number of patients affected is currently not quantified. **SCORE 4**

Project Investment:
This project will require hiring 1.3 FTE of physician medical provider, nurse staffing support, case management support, and a mid-level provider. Additionally, there will be some investment in “front-office” staffing support such as scheduling, check-in, insurance verification, etc. **SCORE 4**

084563802.1.3- "PASS 2"	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE	
Texas Tech Health Science Center – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.5	3.IT-6.1	Percent Improvement over Patient Satisfaction scores	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: [RHP PP Milestone - P-1] Conduct specialty care gap assessment based on community need. Metric(s): [RHP PP Metric - P-1.1] a. Documentation of gap assessment b. Establish Baseline Baseline/Goal: Baseline: Community Needs assessment has been completed. System not yet identified for measuring project impact on targeted populations. Data Source: Community Needs Assessment. Documentation of methodology for measuring impact. Milestone 1 Estimated Incentive Payment: $822,765	**Milestone 2:** [RHP PP Milestone - P-11] Launch specialty care clinics. Metric(s): [RHP PP Metric -P- 11.1] Establish/expand specialty care clinics. Number of patients served by specialty care clinics. Baseline/Goal: Baseline 0. Goal: 500 patient encounters in first 12 months of new clinics. Data Source: Documentation of new clinics. Number of patient encounters tracked by EMR system. Milestone 2 Estimated Incentive Payment: $410,832 **Milestone 3:**		**Milestone 4:** [RHP PP Milestone - P-11] Expand specialty care clinics. Metric(s): [RHP PP Metric -P- 11.1] Establish/expand specialty care clinics. Number of patients served by specialty care clinics. Baseline/Goal: Baseline: 0. Goal: 1000 patient encounters in second 12 months of new clinics. Data Source: Number of patient encounters tracked by EMR system. Milestone 4 Estimated Incentive Payment: $278,825 **Milestone 5:** [RHP PP Milestone - P-6] Develop and implement standardized	**Milestone 7:** [RHP PP Milestone - I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric(s): [RHP PP Metric -I-23.1] Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Baseline: Number of patient encounters of targeted specialties seen in DY4. Goal: Increase number of patient encounters to 1100 Data Source: Number of patient encounters tracked by EMR system. Metric(s): [RHP PP Metric -I-23.2] Documentation of increased number of unique patients, or size of patient

084563802.1.3- "PASS 2"	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE	
Texas Tech Health Science Center – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.5	3.IT-6.1	Percent Improvement over Patient Satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	[RHP PP Milestone - P-20] Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric(s): [RHP PP Metric - P-20.1] Quality Improvement. Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary. Milestone 3 Estimated Incentive		referral and work-up guidelines. Metric(s): [RHP PP Metric - P-6.1] Referral and work-up guidelines, documentation of referral and work-up guidelines. Baseline/Goal: Baseline: No referral and work-up guidelines exist. Goal: Develop referral and work-up guidelines for commonly addressed medical problems. Data Source: Data Source: Referral and work-up policies and procedures documents Milestone 5 Estimated Incentive Payment: $278,825 **Milestone 6:** [RHP PP Milestone - P-20] Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple,	panels. Demonstrate improvement over DY4 Baseline/Goal: Baseline: Total number of unique patients seen in the clinic by targeted specialties seen in DY4 Goal: Increase number of unique patients seen in clinic by 5% over prior year. Data Source: Number of patient encounters tracked by EMR system. Milestone 7 Estimated Incentive Payment: $388,507 **Milestone 8:** [RHP PP Milestone - P-20] Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient

084563802.1.3- "PASS 2"	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE	
Texas Tech Health Science Center – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.5	3.IT-6.1	Percent Improvement over Patient Satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Payment: $410,832		interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric(s): [RHP PP Metric - P-20.1] Quality Improvement. Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary. Milestone 6 Estimated Incentive Payment: $278,825	for the purposes of improvement. Metric(s): [RHP PP Metric - P-20.1] Quality Improvement Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary. Milestone 8 Estimated Incentive Payment: $388,506
Year 2 Estimated Milestone Bundle Amount: $ 822,765	**Year 3 Estimated Milestone Bundle Amount:** $ 821,664		**Year 4 Estimated Milestone Bundle Amount:** $ 836,475	**Year 5 Estimated Milestone Bundle Amount:** $ 777,013

084563802.1.3- "PASS 2"	1.9.2	1.9.2.A-D	IMPROVE ACCESS TO SPECIALTY CARE	
Texas Tech Health Science Center – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.5	3.IT-6.1	Percent Improvement over Patient Satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 3,257,916				

Project Option: 1.7.5 Use Telehealth services to provide medical education and specialized training for targeted professionals in remote locations
Performing Provider Name/TPI: Texas Tech University Health Sciences Center – Amarillo / 084563802
Unique Project ID: 084563802.1.4 – **"Pass 3"**
Project Components: 1.7.5. All
Provider: Texas Tech University Health Sciences Center Infant Risk Center is a web and telephone based clinical resource for information regarding breast-feeding and pharmacology exposures during lactation and pregnancy. In the past year, the Infant Risk Center supplied information to more than 15,000 healthcare providers and patients through either phone consultation or web access. Thomas W. Hale, RPh, PhD, Professor of Pediatrics, Executive Director of the Infant Risk Center and Associate Dean of Research, is a world renowned expert on breast milk pharmacology and has written the standard reference text on the subject.
Intervention(s): This project will expand the delivery of healthcare information regarding pharmacology exposures in breastfeeding and pregnancy to healthcare providers and patients across the state by increasing phone based personnel resources and marketing the free web-based reference material.
Need for the project: The known benefits of breastfeeding are myriad and include decreased rates of obesity and common childhood infections. Our community needs assessment revealed a severe issue with inadequate access to perinatal care (CN7). This project directly addresses that need. Additionally, by decreasing childhood infection rates and obesity, improved breastfeeding rates would also improve the lack of access to primary care (CN1) by decreasing the frequency with which children need to be seen for sick visits. Eventually, this project would also address a lack of providers to manage diabetes (CN4) by improving obesity rates in formerly breast-fed patients. There is an acknowledged paucity of provider knowledge regarding pharmaceutical safety during pregnancy and lactation. The vast number of pharmaceuticals and clinical scenarios makes passive point of care references cumbersome and inefficient. An accessible, interactive resource could improve breastfeeding rates across the state.
Target population: Our target population is healthcare providers caring for lactating or pregnant patients, and patients with concerns about potential drug exposures when lactating or pregnant who are from across our region and the state of Texas. More than 30% of our region's population lives in a rural area, and 16.5% of our population lives below the poverty threshold according to 2000 census data. At the present time, we do not track socio-economic or insurer status of participants, but we anticipate performing a random sampling to quantify number of Medicaid participants and locale of participants.
Category 1 expected patient benefits: The project seeks to improve information delivery through continuous quality monitoring and increase the number of participants accessing the clinical resource by 5% over baseline by DY5.
Category 3 outcomes: IT-11.1 Our goal is to Increase the rate of exclusive breast-feeding in non-native English speaking people in our community by 10% by DY5. This will be assessed using the exclusive breast-feeding rate in a sample pediatric clinic with 75% Medicaid funded patients. The exclusive breast-feeding rate will be calculated by performing a 24 hour recall of a random sampling of non-native-English- speaking-parents with children under 6 months of age. Metric: Percentage of infants less than 6 months old who receive only breast milk, and no other solids or liquids including water (based on 24-hour dietary recall), with the exception of vitamin or mineral supplements and medicines.

The rate will be calculated as follows: (1)# of infants of non-native English speaking parents 0–<6 months exclusively breastfed x 100/total # of infants of non-native English speaking parents 0–<6 months; (2) Numerator Number of infants of non-native English speaking

parents less than 6 months old exclusively breastfed; (3) Denominator Total # of infants of non-native English speaking parents less than 6 months old; (4) Data Requirements 24-hour recall of food consumption of infants less than 6 months old Data source: native language survey sampling in a general pediatric clinic.

Project Option: 1.7.5 Use Telehealth services to provide medical education and specialized training for targeted professionals in remote locations
Performing Provider Name/TPI: Texas Tech University Health Sciences Center – Amarillo / 084563802
Unique Project ID: 084563802.1.4 – **"Pass 3"**
Project Description:

The Surgeon General has issued advisories for our healthcare system to dramatically increase the support for pregnant and breastfeeding women as a measure for increasing health outcomes in our population. Virtually all mothers will use medications while pregnant or breastfeeding, but there is a widespread paucity of access in our healthcare system to information concerning the use of drugs in this population. One of the major reasons women discontinue breastfeeding is so they can take medications, but most healthcare professionals are unsure of the safety of taking the medication while continuing to breastfeed. Some women have been erroneously advised to undergo abortion when exposed to certain medications. Vast numbers of breastfeeding mothers are advised to discontinue breastfeeding so they can be treated with various medications. This advice is frequently untrue. The InfantRisk Center is an evidence-based program capable of expanding the distribution of evidence-based information to all healthcare facilities and the public as well. Our objective is to provide evidence-based information to mothers and clinicians so that breastfeeding or pregnant mothers can receive proper medical information in a timely manner and in a format that allows for improved decision-making by the patient or provider. By improved information access, we will reduce the number of unnecessary abortions, and decrease the unnecessary discontinuation of breastfeeding in mothers.

The goal of this project is to provide electronic health care services to increase physician and patient access to health care and accurate medical information. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health□related education, public health and health administration. Technologies include videoconferencing, the internet, store□and□forward imaging, streaming media, and terrestrial and wireless communications.

Our project encompasses patient consultations, consumer medical and health information delivery, and informal medical education delivery utilizing a web-based e-health patient service site, iPhone applications, as well as traditional phone consultation services. Challenges secondary to language barriers will be addressed by making information available in multiple languages. By DY5, we aim to significantly improve the rate of exclusive breastfeeding in our community.

Project Goals:

The goal of this project is to provide electronic health care services to increase patient access to health care and accurate medical information regarding breastfeeding.

This project meets the following regional goals:

Transform health care by improving patient and provider access to accurate and appropriate healthcare information. Improve the delivery of healthcare decision providing accurate information in the "right time and right place."

Challenges:

The primary challenge of this project is to be able to educate physicians and patients about the availability of this resource. There is a deluge of inaccurate or incomplete medical advice on the internet. We need to present this resource in such a way that it is accessible, relevant, and be able to differentiate from less evidenced base information sources. Many of our regions residents are non-English speaking. We will need to provide information in multiple languages and formats.

5-Year Expected Outcome from Provider and Patients:

Over the course of the 5 year project, we anticipate significantly improving the rate of exclusive breastfeeding in our community.

Starting Point/ Baseline:

Currently, the InfantRisk Center under development has provide more than 17,000 patients and physicians with information about the safety of using drugs in pregnant and breastfeeding mothers in the last year. We presently have the world's best database on the use of these drugs in young mothers. We now need to begin the distribution phase to get this information to physicians, and other HCPs around the state and country. We need to provide this information in digital format in numerous languages, and we need to education the next generation of HCPs who will in the future provide this information to American mothers.

Rationale:

The reason we selected this project is because of one of the greatest challenges facing the U.S. healthcare system which is to provide quality care to a large segment of the population that does not have access to specialty physicians because of factors such as geographic limitations or socioeconomic conditions. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub□specialty providers. Breast milk pharmacology is a unique issue because of the paucity of knowledgeable providers even in communities that are typically considered to have good access to healthcare. The shortage is even more acute in medically underserved populations. The vast majority of healthcare providers simply do not understand the use of thousands of medications in pregnant and breastfeeding mothers. It is a vast field, with more than 5000 individual drugs, vaccines, and disease states that are all individually unique. We are in the unique position of having the most complete database of information on these drugs and diseases in the world. We need to find multiple methods for distributing this data to patients, to their HCPs, and others.

With a land mass area of 268,820 square miles and a growing population of 25.1 million, Texas is the second largest US state by area and population. Its population growth rose more than 18.8 percent between 2000 to 2009, reflecting an increase that is more than double the national growth in this period.2 This rapid growth is attributed to a diversity of sources such as natural increases from the total of all births minus all deaths and to a high rate of net in-migration from other states and countries In its Statewide Health Plan 2011□2016 report31, the Texas Statewide Health Council concluded: "Texas faces particular challenges with respect to physician and other healthcare workforces not primarily because of an overall shortage, but because of sharp disparities in the allocation of healthcare resources to different parts of the state. In the metropolitan areas outside the border, there is one physician in direct patient care for each 573 county residents. In the 32□county border region and in non□metropolitan Texas, the ratios are 2 to 3 times as high." The vast majority of healthcare professionals reside and practice within four primary areas of Texas: Dallas, Houston, Austin, and San Antonio. Moreover, Texas has consistently lagged

behind the US average in the ratio of physician supply per 100,000 of population, and the gap between the two appears to be increasing. In 2009, there were 25 counties with no physicians, and the counties with lowest ratios of providers to populations were by and large in West Texas, South Texas and the Panhandle.

Theoretically, resources such as healthcare would be distributed across the state in accordance with population density and needs. Realistically, however, geographical and economic barriers create significant disparities across the state, with rural and underserved communities enduring significantly greater barriers to accessing the care continuum. The supply ratios for a number of health professionals, including primary care physicians and mental health professionals, are lowest in rural, border and other health professional shortage areas. Data for 2009 indicated that out of the 254 counties in Texas, 118 counties are designated as whole county primary care Health Professional Shortage Areas (HPSAs) due to primary care doctor to patient ratios of 1:3500 or less, and 173 counties (68 percent of the state) are designated as whole county mental health HPSAs.

Given the various benefits observed through the provision of health care via telemedicine, there is a tremendous amount of momentum toward increasing access to care through the use of health information technologies, thereby creating an exciting and central role for innovation and implementation of new and advanced platforms for information delivery.

The known benefits of breastfeeding are myriad, now well documented, and include decreased rates of obesity and common childhood infections. Our community needs assessment revealed a severe issue with inadequate access to perinatal care (CN7). This project directly addresses that need. Additionally, by decreasing childhood infection rates and obesity, improved breastfeeding rates would also improve the lack of access to primary care (CN1) by decreasing the frequency with which children need to be seen for sick visits. Eventually, this project would also address a lack of providers to manage diabetes (CN4) by improving obesity rates in formerly breast-fed patients.

The rationale for individual milestones are as follows:

P□2. Milestone: Conduct needs assessment to identify needed services that could be delivered via telehealth.

Rationale/Evidence: It is important to expand telehealth to areas where greatest need and highest potential for impact is demonstrated in order to have optimal effect.

P□8. Milestone: Create plan to monitor and enhance internet use for telemedicine/telehealth program.

Rationale/Evidence: The Internet has considerable potential as a medium for tele□consultations, monitoring patient condition, and other unforeseen applications in telemedicine. Use of the Internet for tele-consultations and other telemedicine applications will move these applications into the mainstream of other communications used by physicians and other health care providers, decreasing the need for separate facilities (equipment, space, etc.), procedures, and telecommunications standards for telemedicine. Any developments that reduce the "separateness" of telemedicine from other parts of the health care system will improve its acceptance and efficiency.

P□10. Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self□reported data and sampling that is sufficient for the purposes of improvement.

Rationale/Evidence: The rate of testing of new solutions and ideas is one of the greatest predictors of the success of a health care system's improvement efforts.

I□17. Milestone: Improved access to needed services, e.g. health information and patient education, counseling, etc.

Rationale/Evidence: In evaluation, utilization is often used as a proxy for access to care. For example, in one network's telepsychiatry program, 46% of those patients taking part in the program were seeing a psychiatrist for the first time, suggesting that psychiatric assistance was not available to these individuals before it was offered through telemedicine. It is important to note, however, that an initial surge in telemedicine utilization may reflect pent□up demand and may subside once this consultation backlog is handled. That is, an evaluation of access may reveal a spike in patient volume at the onset of a telemedicine program as patients who have yet to seek care may have their initial appointment via telemedicine. Following these initial visits, the immediate needs of the population have been met and thus the number of visits may drop until a steady, maintainable level is reached. Further, any estimate of the rate of patients seeing a provider for the first time in a telemedicine
program should be compared to the rate for patients in conventional settings.

Project Components:

- Use telehealth services to provide medical education and specialized training for targeted professionals in remote locations: Our web-based and telephone based outreach media is perfectly designed to improve access for remote medical providers to "just in time" clinical information and convenient self-directed education regarding breastfeeding and pharmacology.
- Quality improvement - An essential part of any new endeavor is the ability to continually assess impact, determine areas for improvement and be able to enact those improvements in a time sensitive manner. As we expand our outreach project, we will have an exceptional opportunity and need to adapt processes according to real-time data feedback for process improvement. Rapid cycle improvement is a somewhat generic descriptor of the continued application of the Deming cycle for process improvement. We intend to utilize the Deming cycle with data including standard clinic metrics, 360 degree feedback loops and periodic meetings with stakeholders for process and outcome improvement.

Unique community need identification numbers the project addresses:

- CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.4 - High incidence of obesity, diabetes mellitus, and heart disease
- CN.7 – Insufficient maternal and prenatal care especially the first trimester teen pregnancy, high percentage of unmarried mothers

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

This is an innovative project that allows us to deliver up-to-date and accurate information using a low cost delivery system directly to patients and "front-line" physicians. The focus of the project (breastfeeding) is known to decrease the risk of obesity, arguably the largest national public health problem in our country.

Related Category 3 Outcome Measures:

IT 11.1.

By improving access to safety information regarding breastfeeding and breast milk pharmacology, we anticipate improving the rate of exclusive breastfeeding in our community. Definitions of exclusive breastfeeding and calculation of rates will be taken from the Specifications Manual for Joint Commission National Quality Measures available at http://manual.jointcommission.org. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC□01: Elective Delivery, PC□02: Cesarean Section,

PC□03: Antenatal Steroids, PC□04: Health Care□Associated Bloodstream Infections in Newborns, PC□05: Exclusive Breast Milk Feeding). Anecdotal evidence suggests that many non-native-English speaking new mothers do not breastfeed exclusively, even if they may have breastfed a previous child in their country of origin. Baseline results of exclusive breastfeeding in non-native-English speaking children will be established during DY3 . By DY5, we anticipate a 10% increase in exclusive breastfeeding rates over baseline results.

Results will be determined as follows: The exclusive breast-feeding rate will be calculated by performing a 24 hour recall of a random sampling of non-native-English-speaking-parents with children under 6 months of age. Metric: Percentage of infants less than 6 months old who receive only breast milk, and no other solids or liquids including water (based on 24-hour dietary recall), with the exception of vitamin or mineral supplements and medicines.

The rate will be calculated as follows: (1) # of infants of non-native English speaking parents 0–<6 months exclusively breastfed x 100/total # of infants of non-native English speaking parents 0–<6 months; (2) Numerator Number of infants of non-native English speaking parents less than 6 months old exclusively breastfed; (3) Denominator Total # of infants of non-native English speaking parents less than 6 months old; (4) Data Requirements 24-hour recall of food consumption of infants less than 6 months old Data source: native language survey sampling in a general pediatric clinic.

Reasons/rationale for selecting the outcome measures:

Rationale/Evidence: "Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007). A recent Cochrane review substantiates the benefits (Kramer et al., 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2010 and the CDC have also been active in promoting this goal" (Specifications Manual for Joint Commission National Quality Measures (v2012B)). The known benefits of breastfeeding are myriad and include decreased rates of obesity and common childhood infections. Our community needs assessment revealed a severe issue with inadequate access to perinatal care (CN7). This project directly addresses that need. Additionally, by decreasing childhood infection rates and obesity, improved breastfeeding rates would also improve the lack of access to primary care (CN1) by decreasing the frequency with which children need to be seen for sick visits. Eventually, this project would also address a lack of providers to manage diabetes (CN5) by improving obesity rates in formerly breast-fed patients.

Relationship to other Projects: There are no other similar projects in the USA that cover this region and the whole USA. This is at present the largest such program in the USA.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: N/A

Project Valuation:

Achieves Waiver Goal: This project addresses the Triple Aim of high quality and patient centered care in the most cost-effective ways. Improving breastfeeding rates directly improves the health of a child in a cost-effective preventive manner in both the short and long term. Although the primary project is not specifically targeted to economically disadvantaged populations, the dissemination of information via commonly utilized media (telephone and internet) improves access for all patients regardless of economic status. The project provides 1) accurate and rapid information on the use of drugs in pregnant and breastfeeding mothers. It will do so in multiple languages, and multiple

networking systems, including telephones, webpages, and by telephone calls directly to the center. We already have an extensive database of 17,000 callers this last year. **SCORE 4**

Addresses Community Needs: Our community needs assessment revealed a severe issue with inadequate access to perinatal care (CN7). This project directly addresses that need. Additionally, by decreasing childhood infection rates and obesity, improved breastfeeding rates would also improve the lack of access to primary care (CN1) by decreasing the frequency with which children need to be seen for sick visits. Eventually, this project would also address a lack of providers to manage diabetes (CN5) by improving obesity rates in formerly breast-fed patients. **SCORE 3**

Project Scope/Size: This project will provide care to all mothers in this region who seek advice about various diseases, pregnancy, breastfeeding, and the use of drugs in these respective groups. Additionally, patients across the state and nation can access the service. **SCORE 5**

Project Investment: This project would require hiring of nursing personnel to handle calls, networking and information technology people to build the websites, iPhone/Android apps. We would also require medical translators. **SCORE 3**

084563802.1.4 – "PASS 3"	1.7.5	N/A	Introduce, Expand or Enhance Telemedicine/Telehealth
Texas Tech Health Science Center – Amarillo			084563802
Related Category 3 Outcome Measure(s):	084563802.3.6	3.IT-8.9	Other Outcome Improvement Target: Breastfeeding

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [RHP PP Milestone - P□2] Conduct needs assessment to identify needed services that could be delivered via telehealth. Metric(s): [RHP PP Metric - P□2.1] Submission of completed needs assessment. Baseline/Goal: Baseline: Not yet defined; Goal: Complete and submit needs assessment. Data Source: Community Needs Assessment. Milestone 1 Estimated Incentive Payment: $ 76,532	**Milestone 2:** [RHP PP Milestone - P□8] Create plan to monitor and enhance internet use for telehealth program. Metric(s): [RHP PP Metric -P- 8.1] Documentation of expansion of services utilizing the internet as a medium. Submission of plan identifying which services can be made available through internet applications as well as steps to implement these services. Baseline/Goal: Baseline: Formal plan does not exist. Goal: Develop and submit plan. Data Source: Program plan. Milestone 2 Estimated Incentive Payment: $ 76,428	**Milestone 3:** [RHP PP Milestone - P□10] Quality Improvement Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric(s): [RHP PP Metric -P- 10.1] Metric: Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis.	**Milestone 5:** [RHP PP Milestone - I-17] Improved access to needed services, e.g. health information and patient education, counseling, etc. Metric(s): [RHP PP Metric -I□17.1] Percentage of patients utilizing the telehealth program are using it for the first time. Numerator: Number of first time users of program Denominator: Total number of users of program Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: 5% of participants will be new participants to this program compared to baseline. Data Source: Program records.

084563802.1.4 – "PASS 3"	1.7.5	N/A	Introduce, Expand or Enhance Telemedicine/Telehealth	
Texas Tech Health Science Center – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.6	3.IT-8.9	Other Outcome Improvement Target: Breastfeeding	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary. Milestone 3 Estimated Incentive Payment: $38,903 **Milestone 4:** [RHP PP Milestone - I-17] Improved access to needed services, e.g. health information and patient education, counseling, etc. Metric(s): [RHP PP Metric -I□17.1] Percentage of patients utilizing the telehealth program are using it for the first time. Numerator: Number of first time users of program Denominator: Total number of users of program Baseline/Goal: Baseline: This metric is not	Milestone 5 Estimated Incentive Payment: $36,137 **Milestone 6:** [RHP PP Milestone - P□10] Quality Improvement Milestone: Evaluate project data. Create responses and new ideas with tests of new processes, informational tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based both on self-reported data and data derived from calls to the system, use of electronic data management, and calls to the center to create and implement changes for improvement. Metric(s): [RHP PP Metric - P□10.1] Metric: Number of new ideas, practices, tools, or solutions tested. Baseline/Goal:

084563802.1.4 – "PASS 3"	1.7.5	N/A	Introduce, Expand or Enhance Telemedicine/Telehealth	
Texas Tech Health Science Center – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.6	3.IT-8.9	Other Outcome Improvement Target: Breastfeeding	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			currently being tracked. Goal: 2.5% of participants will be new participants to this program compared to baseline. Data Source: Program records. Milestone 4 Estimated Incentive Payment: $38,903	Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary. Milestone 6 Estimated Incentive Payment: $ 36,137
Year 2 Estimated Milestone Bundle Amount: $ 76,532	**Year 3 Estimated Milestone Bundle Amount:** $ 76,428		**Year 4 Estimated Milestone Bundle Amount:** $ 77,806	**Year 5 Estimated Milestone Bundle Amount:** $ 72,274
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 303,040				

Project Option: 1.2.4 Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)
Unique Project ID: 084599202.1.1
Performing Provider: Texas Tech University Health Sciences Center – Lubbock/084599202

Provider: The Texas Tech Physicians of Lubbock, Department of Family & Community Medicine is currently made up of twenty (20) attending/ faculty practitioners and up to thirty (30) resident positions. Combined these practitioners serve more than 30,000 patients annually. This department of the TTUHSC School of Medicine is a significant provider of General, Ambulatory, Preventive Medicine, and Employee and Student Health services.
Intervention(s): This Category-1 project's milestones are designed to produce and introduce ever-increasing numbers of qualified family medicine practitioners into communities in a shorter, more concentrated training fashion, as well as provide opportunities to learn in more underserved rural settings.
Need for the project: TTUHSC, School of Medicine will lead in addressing the most pressing need in RHP12 and the State by development and employing of innovative strategies that directly answers the issue of a severe shortage of primary care providers, and the access thereof.
Target population: The department's current payer mix includes approximately 25% of Medicaid and approximately 14% of uninsured and under-insured patients. Many of the core components of this multi-layered intervention (Medical School; training, Student-run Free Clinic, and increased residency numbers) will serve the Medicaid, uninsured, and significantly under-insured population both within the Lubbock MSA and the rural communities of West Texas. From September 2011-August 2012, Texas Tech Physicians of Lubbock, Department of Family and Community Medicine provided healthcare services through 39,351 total patient encounters, of which over 13,450 (~34%) were Medicaid/ Uninsured patients.
Category 1 expected patient benefits: The project seeks to deliver to the market an increased number of primary care providers who, through increased philanthropical educational activities and exposure, are more culturally attuned and sensitive to the poorer populations of the region and state.
Category 3 outcomes: While not totally developed, this project's Category-3 outcomes will seek to demonstrate increased access to primary care services, yielding better patient outcomes, and reducing the need for patients to enter the healthcare system through hospital emergency rooms.

Project Option: 1.2.4 Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)
Unique Project ID: 084599202.1.1
Performing Provider: Texas Tech University Health Sciences Center – Lubbock/084599202

Project Description:

Texas Tech University Health Sciences Center (TTUHSC) Department of Family Medicine, proposes to strengthen the Family Medicine Accelerated Track (FMAT) Program, expand the Student-Run Free Clinic, and develop new residency positions in an effort to increase family medicine practitioners in the RHP 12 counties.

In the face of insistent calls for an expanded primary care workforce, we propose the Texas Tech Primary Care Training Innovation Initiative (PCTII), a true innovation in health care education. The PICTII program aims to re-balance of the Texas physician workforce in favor of primary care through expanded primary care training programs, all with a primary locus within HPSAs. In an effort to define the population that we wish to serve, the following statistics were gathered from the RHP 12 Needs Assessment Summary.

Counties	Population	Primary Care Physicians	Physicians/100,000 Residents
Rural	352,329	187	38.9
Total	519,102	460	73.4

RHP 12 Need Assessment Summary, 2012

This Infrastructure Development/ Increase Training of Primary Care Workforce Project will increase training of the primary care physician workforce through the following project goals:

- To strengthen and sustain the Family Medicine Accelerated Track (FMAT), an innovative three-year accelerated medical school curriculum at the Texas Tech University Health Sciences Center (TTUHSC) School of Medicine; the FMAT program increases primary care capacity and expands the primary care workforce by producing family physicians more quickly and at less cost.

- To expand and strengthen the TTUHSC School of Medicine Student-Run Free Clinic, in which medical students, under the guidance of faculty and resident physicians, learn to provide culturally competent urgent and chronic primary care at no charge to an indigent population that might otherwise seek care in area emergency rooms.

- To develop new residency positions available to provide post-graduate training and thus accommodate additional medical students entering the family medicine/ primary care workforce.

The PCTII program's broad outcomes are to increase expand or establish primary care training programs and thus improve future health care capacity in Texas. Specific PCTII outcomes include:

Family Medicine Accelerated Track

- A full complement of faculty and staff available for the teaching programs involved with the FMAT program, at both pre-doctoral and residency levels, with the addition of 2 faculty FTE and 1 staff FTE in the Department of Family & Community Medicine
- Sustained scholarship support for FMAT pre-doctoral students, with the establishment of a scholarship fund for students enrolled in the FMAT program; these scholarships are integral in the reduction of student debt and hence a barrier to primary care specialty selection
- An effective and operational curriculum, with assessment tools and program metrics, available to all Texas medical schools and training sites; this curriculum will include a new series of curricular experiences that will assist learners in systems-based practice that leads to lower health care costs through improvement in decision-making, system efficiencies and coordination of resources

TTUHSC Student-Run Free Clinic

- A Student-Run Free Clinic that has doubled capacity and expanded opportunities to see and provide care for more needy patients, with the addition of new sites or locations and/or additional days at the present Lubbock Impact site, operating under the umbrella of the "South Plains Area Free Clinic"
- A Student-Run Free Clinic that has permanent staffing, including at least 1 physician faculty FTE and 1 staff FTE, to provide patient care oversight as well as structured opportunities for student and resident learning
- A Student-Run Free Clinic that has expanded and sustained resources for patient referrals and to provide integrated, multidisciplinary care

Family Medicine Residency Program Expansion

- Adequate family medicine residency positions, possibly including rural tracks or programs, with an emphasis in communities designated as HPSAs, to accommodate as many as 12 family medicine positions in each of three training years
- Support for new family medicine residency position salary and benefits, as well as to recruit additional residents

- A set of curricular experiences in the Family Medicine residency program that focus on the medical home model and that highlight residents' continuity of care for their panel of patients

Family Medicine Accelerated Track. At the outset of the FMAT program, we anticipated what might be considered "standard" challenges to implementing an ambitious curricular initiative: resistance to change among faculty and students, finding time and resources, reconciling differences among proposed strategies and disparate departments that may view one another as competitors for students and residents. Based on our experience with the FMAT program thus far, the goals proposed by this project are designed to address the challenges that we have indeed faced: the need for additional faculty, student support, curricular resources, and residency training opportunities. The development of new residency training positions is not without its challenges—new or expanded programs must meet ACGME and Review Committee guidelines, and approval/ accreditation must follow carefully defined procedures. Nonetheless, TTUHSC's Family Medicine residency program recently received 4 years' reaccreditation, and the Plainview RTT was launched in July 2012 as a strong collaboration and model for the PCTII program's goals.

For this 1.2.4 PCTII Project, we will ensure full staffing and support for the FMAT program by adding 2 faculty FTE and 1 staff FTE. These new faculty will teach in the FMAT1 summer course, an intensive 8-week experience team-taught by family physician and basic sciences faculty that includes clinical correlations to basic sciences content essential to the family medicine clinical clerkship. They will also serve as clinical mentors in the longitudinal FMAT2 clerkship, as well as providing teaching and precepting in the FMAT3 capstone course at the end of students' third year of training. These faculty members will continue to mentor and teach FMAT trainees as they transition to residency training at TTUHSC. Additional staff will provide the extensive support required for this intensive program, working closely with students and faculty on scheduling and other support activities. Faculty development and mentoring training will be necessary for both new and continuing faculty, which will be a project activity as well. Additionally, this project will ensure that the FMAT program can provide scholarship support across students' second year of medical school; this student assistance will be essential as previously awarded support from the Health Resources Services Administration (HRSA) ends. Finally, resources from this 1.2.4 Project will drive the creation of a new longitudinal curriculum to be delivered in the FMAT2 course. This experience will have an explicit focus on health care cost, efficiency, decision-making, and accountability. By including such content in a track that is likewise devoted to teaching medical students about coordinated care and prevention of disease in ambulatory settings, we can instill in young doctors an appreciation for cost accountability and the consequences of their own decision-making, in the context of systems-based practice. Teaching content for this curriculum, as well as faculty development for the Consortium, will be delivered asynchronously, using web-based modules and downloadable presentation and reading materials.

Student-Run Free Clinic. The TTUHSC Student-Run Free Clinic has been a "labor of love" for the students and faculty involved and invested in its establishment and growth. Similarly, many community relationships have been developed thus far. Thus, we anticipate typical growing pains associated with expansion of sites, locations and staffing, such as resistance to change, developing new protocols and relationships, determining priorities for sites, and ensuring that patients understand where to find resources. Based on our experience

with the Free Clinic program thus far, the goals proposed by this project are designed to address the challenges that we have previously faced: the need for additional faculty, resources and opportunities for patient care—especially in rural settings, and interprofessional training opportunities.

For this 1.2.4 PCTII Project, we will make a major investment in the TTUHSC Student-Run Free Clinic. We will have the opportunity to transition faculty involvement from a totally volunteer to at least 1 FTE of faculty time and at least 1 FTE of staff support. Indeed, what has most limited the growth of Free Clinic activities has been the lack of faculty physician oversight. Furthermore, we will at least double the capacity of the Free Clinic to care for underserved patients in our community through one of several ways—by adding days (the Clinic is currently open only 1 night per week), sites, or locations. Over the entire course of the 1.2.4 Project, we may have the opportunity to make all of those additions, adding days at the current site, making regular visits to rural communities, or adding wholly new sites in Lubbock or in surrounding areas. In any event, through the resources available through this 1.2.4 Project, we can perform better community outreach and undertake quality improvement initiatives. For example, we will be able to better assess the role of the Free Clinic in reducing emergency room visits among our patient population, which is a key goal of the facility.

Family Medicine Residency Training. We expect to increase the number of providers trained in primary care, therefore, increasing access to primary care physicians for patients. We realize that primary care is underserved in Region 12 (F. Marie Hall Institute for Rural and Community Health), and will expand the number of providers who can help the population with primary care. Among 43 Rural RHP 12 counties, 17 are federally designated shortage areas and 35 of 46 of the entire RHP 12 are below the Texas average of 68 primary care physicians per 100,000 population. Our 5-year expected outcome of increasing the number of primary care workforce, and thus expanding access can be achieved by strengthening and sustaining the FMAT program, expanding the student run clinic, and developing new residency positions in the primary care sector. These programs seek to provide additional primary care physicians in all counties.

For this 1.2.4 PCTII Project, we will expand residency slots in the Lubbock Family Medicine Residency Program to support 12 positions in each of three training years. Options for residency expansion include slots in Lubbock as well as rural tracks in RHP12/West Texas communities with inpatient and outpatient facilities and medical personnel to support residency training for Years 2 and 3; our model for this is a Rural Track already in place in Plainview and supported by a HRSA Primary Care Residency Expansion grant. Resources from this Project will also cover residents' salary and benefits, recruitment costs, and other expenses related to residency expansion, such as for office space, lab coats, continuing medical education, travel between Lubbock and residency training sites, and so forth. This Project will also drive development of a set of curricular experiences in the Family Medicine residency program that focus on the medical home model and that highlight residents' continuity of care for their panel of patients. This curriculum will be delivered through both didactic and experiential modes for all residents in the Lubbock Family Medicine program.

Starting Point/Baseline: As of September, 2012, the TTUHSC FMAT program has eight students in the first class (FMATc2013); these students have completed two years of medical school and the first two FMAT-specific courses. All of these students passed the USMLE

Step 1 exam (taken in June 2012), a key milestone in the assessment of student and program effectiveness. These students will graduate and enter residency training in the summer of 2013. The seven students in FMATc2014 have completed their first year of medical school and the FMAT1 summer enrichment experiences; they will begin a longitudinal family medicine clerkship on August 8, 2012. Additionally, as of February 2013, the FMATc2015 has 8 students who will begin their FMAT coursework in June 2013.

The TTUHSC Free Clinic began operation in 2009 at Lubbock Impact, a former church that is now a non-denominational 501(c)(3) organization. The Free Clinic arose from the interest of medical students at TTUHSC, who continue to provide most of the staffing (8-10 medical student volunteers with a Leadership Team comprised of four second-year medical students). Oversight is provided by volunteer TTUHSC physician faculty, usually 3-5 per night. The Clinic operates on Wednesdays, following a free meal at 5:00 pm, and typically provides care for 25-30 patients each week. Student interest in volunteering is extremely high, with the schedule booked months in advance. Students are recruited via a school-wide e-mail and online registration.

The Family Medicine residency program in Lubbock has 10 positions per year; two of those were funded by a HRSA Primary Care Residency Expansion (PCRE) grant that began in 2010, so that program now has 28 positions and will have 30 as of July 2013. The two positions funded by the PCRE grant are also part of a new rural training track (RTT) in Plainview, Texas, where residents spend 1 year in Lubbock in a typical rotating internship, followed up with 20 months from the remaining 24 in rural health care settings, at Covenant Hospital Plainview, at the Regence Health Network's FQHC (were residents maintain their continuing clinics), or with Plainview community physicians. All sites where TTUHSC-Lubbock family medicine residents train have HPSA designations (TTUHSC-Lubbock primary care clinics HPSA ID# 1489994875; Regence Health Network-Plainview HPSA ID# 148999485D).

Rationale: Current and prospective shortages in the primary care physician workforce are well documented, especially in Texas. Although physician capacity among specialists has kept up with the overall population growth in Texas, primary care physician capacity has not. Nor have the number of entry-level primary care residency slots kept pace with the growth in Texas medical school enrollment. The PCTII project will address these shortages at both the undergraduate and graduate medical educational levels. It will also use innovative curricular modalities and positive primary care exposure--significantly, exposure within a setting that itself will expand primary care access to an undeserved population.

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. The most common explanation for shortages in the primary care physician workforce is financial, related both to student debt loads (which have increased dramatically in recent years) and to the disparity in compensation between primary care and subspecialty physicians, issues specifically addressed by the FMAT program.

Although the number of Texas medical graduates is expected to peak in 2015, the number of available graduate medical education (GME) positions have not kept pace, and the Texas Higher Education Coordinating Board predicts a shortage of 400 GME positions. The shortage of GME positions or residency slots maybe the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage. Thus, the addition of family medicine positions at TTUHSC will address both the GME shortage and the need for additional primary care physicians.

Within RHP12, the primary care provider shortages are especially acute. The specific RHP community need that this project addresses is *CN.1--Severe primary care provider shortage, wait time, expense, lack of insurance, & access to care.* This project selection has no required "core components." This project does represent a significant enhancement to existing but newly developed healthcare workforce training initiatives – the TTUHSC FMAT program and the Student-Run Free Clinic and will develop new residency positions. Each of the milestones and metrics are reflective and relative for the objective of this initiative and add directly to the desired outcome. Texas Tech Physicians of Lubbock is a 260+ multi-specialty group practice that provides over 250,000 patient encounters per year to the South Plains region of Texas. From September 2011-August 2012, Texas Tech Physicians of Lubbock, Department of Family and Community Medicine provided healthcare services through 39,351 total patient encounters, of which over 13,450 (~34%) were Medicaid/ Uninsured patients. Each family medicine resident is required to have seen at least 1650 continuity patients during their three years of training (although most have more), and family medicine faculty members typically see 1000 continuity patients per year. Thus, the addition of 2 faculty and 6 residents will add more than 5,300 patient visits, of which over 1,800 can reasonably be expected to be Medicaid and uninsured patient encounters. It is expected that this project will provide sustainable year-over-year benefit to the region and State of Texas patients long beyond the initial Texas 1115 Waiver demonstration years.

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: N/A

Relationship to Other Performing Providers' Projects in the RHP: Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Plan for Learning Collaborative: N/A

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	• Relative to other proposed projects presented by TTUHSC-Lubbock, this project will improve the workforce and healthcare infrastructure of RHP12 to better serve the Medicaid, uninsured, and underinsured patient base of West Texas because of its emphasis and clinical rotation sites, many within federally-designated primary care HPSAs. The regional exposure of these clinical rotations frequently provide for a number of medical graduates to set their practice up in these more rural & frontier areas of the region. Additionally, the expansion of the free clinic, and its use as a training facility will address the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways while simultaneously providing for a heightened sensitivity to providing care to patients less fortunate.	**4**
Addresses Community Need(s)	As identified in the project description: In the face of insistent calls for an expanded primary care workforce, we propose a true innovation in health care: a re-balance of the Texas physician workforce in favor of primary care by proposing a project that will establish or expand primary care training programs, all with a primary locus within HPSAs. This project will specifically address, what is considered one of the most critical of RHP12's and the State's community needs: *C.1 - the severe primary care provider shortage, wait time, expense, lack of insurance, and access to care*. While it may not address but one specifically for the region, it clearly is addressing one of two needs deemed and classified as "most critical" for the region. We believe this project will definitely "move the dial" by graduating family practice-focused medical professions, in greater numbers, at a reduced cost, and in shorter time frames.	**5**
Project Scope/Size	Medium immediate scope, but this project will have vast impact and positive influence over the healthcare workforce and structure of this region over the long term. This is a building process that will generate and regenerate positive output for many years after the initial startup.	**3**
Project Investment	This project will require a relatively large investment, especially in human resources, time for fully develop and expand, and development of organizational priorities within the project itself.	**4**

084599202.1.1	***1.2.4***	***N/A***	***Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.1*	*TBD*	*TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Expand Primary care training for primary care physicians Metric 1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: An increase of 2 FTEs in the number of faculty to support expanding training program. (FMAT Program Area) Data Source: HR documents, faculty lists, or other documentation Metric 2 [P-2.3]: Develop alternative primary care training modalities, including a 3-year accelerated medical curriculum. Goal: To develop a more focused and interactive education training modality and experience (FMAT Program and Free Clinic Areas) Data Source: Training Program Documentation Milestone 1 [P-2] Estimated Incentive Payment *(maximum amount):* $484,607	**Milestone 3** [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites Metric 1 [P-9.1]: Submit clinical teaching tools Goal: Published comprehensive curriculum and evaluation plan for a 3-year family medicine accelerated track and teaching tools for students and faculty who see patients at free clinics (FMAT Program Area) Data Source: Enlist institutions that provide clinical teaching as consultants. Milestone 3 [P-9] Estimated Incentive Payment *(maximum amount):* $505,551 **Milestone 4** [I-11]: Increase primary		**Milestone 5** [P-2]: Expand primary care training for primary care physicians Metric 1 [P-2.1]: Expand the primary care residency training programs and/or rotations Goal: By increasing primary care residency training slots we will help address the primary care workforce shortage (Family Medicine Residency Program Area) Data Source: Training Program Documentation applications and agreements to expand. Milestone 5 [P-2] Estimated Incentive Payment *(maximum amount):* $360,548	**Milestone 8** [I-13]: Increase the number/proportion of primary care residency/trainee graduates choosing primary care as a career Metric 1 [I-13.1]: Number of primary care residency/trainee graduates working in primary care settings as demonstrated by a greater percentage increase in current academic year primary care (FM) residency graduates over the same percentage of primary care (FM) residency graduates in the academic year ending in DY1. [(DY5:FM Residents/All Residents)- (DY1:FM Residents/ All Residents)] Goal: Continuing high numbers of family medicine residents continuing to practice primary care and an increase in the number of overall graduates in primary care practices (Family Medicine Residency Program and FMAT Program Areas) Data Source: Program and follow survey documentation Milestone 8 [I-13] Estimated Incentive Payment *(maximum amount):* $1,045,065

084599202.1.1	***1.2.4***	***N/A***	***Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.1*	*TBD*	*TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-3]: Expand positive primary care exposure for residents/trainees. Metric 1 [P-3.1]: Develop mentoring program with primary care faculty and new trainees involved in the FMAT program Goal: Foster primary care trainees' interest in pursuing primary care careers (FMAT Program Area) Data Source: Mentoring program curriculum and/or program participant list Metric 2 [P-3.2]: Train trainees in the medical home model; have primary care trainees participate in medical homes by managing panels Goal: To expose trainees' to evolving primary care delivery models (Family Medicine Residency Program Area) Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee Milestone 2 [P-3] Estimated Incentive Payment *(maximum amount):* $484,607	care training and/or rotations Metric 1 [I-11.3]: Increase the number or percent of culturally competent trainees eligible for existing Texas residency programs through the FMAT program Goal: To address the need for cultural competency training available to Texas primary care residents (FMAT Program and Free Clinic Areas) Data Source: Cultural Competency training program matriculation records. Metric 2 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program Goal: To ensure that the FMAT and Family Medicine residency programs are being adapted to address needs and further foster a commitment to serve in primary care (FMAT Program, Free Clinic, and Family Medicine Residency Program Areas) Data Source: Trainee satisfaction assessment tool Milestone 4 [I-11] Estimated Incentive Payment *(maximum amount):* $505,550		**Milestone 6** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents Metric 1 [P-10.1]: Submit application for ACGME approval for residency position expansion Goal: To increase the number of primary care residents in an effort to increase patient access to care for all, including Medicaid. (Family Medicine Residency Program Area) Data Source: Submitted application including evidence justifying the number of residents needed Milestone 6 [P-10] Estimated Incentive Payment *(maximum amount):* $360,548 **Milestone 7** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.4]: Increase the number of primary care residents	

084599202.1.1	***1.2.4***	***N/A***	***Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.1*	*TBD*	*TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			and/or trainees by 2 in each residency class over DY1 numbers (baseline) Goal: To increase the number of primary care residents (Family Medicine Residency Program Area) Data Source: Program enrollment records Milestone 7 [I-11] Estimated Incentive Payment *(maximum amount):* $360,547	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $969,214	Year 3 Estimated Milestone Bundle Amount: $1,011,101		Year 4 Estimated Milestone Bundle Amount: $1,081,643	Year 5 Estimated Milestone Bundle Amount: $1,045,065
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,107,023				

Project Option: 1.6.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce emergency department use for non-emergent conditions and increase patient access to health care.
Unique Project ID: 084599202.1.2
Performing Provider: Texas Tech University Health Sciences Center-Lubbock / 084599202

Provider: The Texas Tech Physicians of Lubbock, Department of Pediatrics is currently made up of forty-four (44) attending/ faculty practitioners and up to twenty-on (21) resident positions. Combined these practitioners see more than 46,000 pediatric outpatient and ambulatory visits annually. This department of the TTUHSC School of Medicine is a significant provider of cardiology, critical care, developmental medicine, general/ ambulatory, in-patient medicine, newborn, genetic counseling, infectious diseases, neonatology, neurosurgery, neurology, oncology, and pulmonary services.

Intervention(s): This project will develop and implement an after-hours and weekend nurse medical advice call service for pediatric patients and caregivers in an effort to reduce unnecessary use of hospital emergency room services. Additionally, next business day appointments will become a part of the after-hours call services to facilitate timely and appropriate treatments and follow-up

Need for the project: Non-emergency after-hours and weekend medical-related services are inappropriately delivered in hospital emergency rooms; thereby extending unnecessary higher delivery cost and hindering the spirit and intention behind the emergency room environment.

Target population: Office visit encounters from 9/2011 – 8/2012 for the department of pediatrics were in excess of 45,800; of which more than 28,400 (~62%) of those patient encounters served Medicaid and the uninsured patients. It is anticipated that approximately 25% or over 11,000 annually will initially utilize this access to medical advice service. Initial Medicaid and uninsured utilization estimates are in excess of 6,800 service encounters. All pediatric patients, both current and future patients of this department will benefit dramatically from this initiative.

Category 1 expected patient benefits: The project seeks to reduce unnecessary cost and congestion associated with the non-emergency treatment of health- & medical-related issues in hospital emergency rooms by dispensing appropriate medical advice and establishing timely follow-up appointments in the pediatric clinics of Texas Tech Physicians Pediatric clinics. This Catregory-1 project is specifically designed to address the access to care and the appropriateness of care needs that are so prevalent in RHP12, as indicated in the region's needs assessment.

Category 3 outcomes: While not totally developed, this project's Category-3 outcomes seeks to provide better patient outcomes commensurate with the "triple aims" objectives by redirecting needless expensive care provided in emergency department environments

to less costly, more appropriate and timely office settings for the provision of healthcare services.

Project Option: 1.6.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce emergency department use for non-emergent conditions and increase patient access to health care.
Unique Project ID: 084599202.1.2
Performing Provider: Texas Tech University Health Sciences Center-Lubbock / 084599202

Project Description:

Texas Tech University Health Sciences Center (TTUHSC) Department of Pediatrics proposes a "Person-to-Person" Medical Advice Service ("P2P") that allows patients to reach medical professions during non-business hours and thus seeks to reduce non-emergent use of hospital Emergency Departments; thereby directing the provision of healthcare services in a more appropriate and cost efficient environment while increasing access.

The project will develop and implement a process that allows the patient to reach a medical professional immediately by telephone between the hours of 5pm and 8am, Monday – Friday and from 8am Saturday – 8am Monday. Our current hours of operation allow us to provide access to medical advice, and this expansion of medical advice through this project will allow for 24 hour, 7-days per week available medical advice. This service, once implemented, will provide for both a "live" medical advice service and create a next-morning/ -available (for some weekend calls) follow up clinic appointments for patients that call overnight and are advised not to go to hospital emergency departments (ED). This project will address both the regional goals of delivering medical services in the most appropriate setting and reducing the cost of healthcare provisions by reducing the unnecessary, non-emergent use of hospital EDs.

The goal of this project is to provide medical advice so that patients who are in need of it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased. By increasing direct access and medical feedback to patients, the project further seeks to see reduced urgent care and hospital ED use for non-emergency conditions. According to the RHP 12 Needs Assessment Survey, *CN.1: Severe primary care provider shortage wait time, expense; lack of insurance, access to care* the below project objectives indicate that the RHP 12 counties could benefit from "Person-to-Person" Medical Advice Service. The project's objectives include:

- Increase direct access to health care professionals
- Seek to provide medical service during non-business hours
- Reduce the use of hospital Emergency Departments

One of the biggest challenges is that patient populations without an established primary care physician relationship regularly utilize hospital EDs for their primary health care needs. This phenomenon is also evident with current patients' of Texas Tech Physicians who cannot have access to medical advice during off clinic hours. The P2P project will allow all patient mix types, including Medicaid,

underinsured and uninsured, to immediately reach a health care professional for medical advice. The P2P project will also directly service both current and non-current pediatric patients of the practice (Texas Tech Physicians of Lubbock).

Our five-year expected outcome is to increase access to primary care physicians for pediatric patients residing in Lubbock County, and the nine contiguous counties surrounding Lubbock County. Concurrently, the P2P project will be responsible for reducing overall healthcare delivery cost by redirecting a percentage of hospital ED utilization to more appropriate care delivery environments through "live" medical advice and access to next-day and next-available clinic appointments/ follow-ups for non-emergent medical issues. Office visit encounters from 9/2011 – 8/2012 for the department of pediatrics were in excess of 45,800; of which more than 28,400 (~62%) of those patient encounters served Medicaid and the uninsured patients. It is anticipated that approximately 25% or over 11,000 annually will initially utilize this access to medical advice service. Initial Medicaid and uninsured utilization estimates are in excess of 6,800 service encounters. Additionally, it is expected that this service's encounters will grow at an estimated year-over-year rate of $\geq$ 10% each year during the demonstration period.

Starting Point/Baseline: N/A - Numbers for clients served and numbers for non-emergent hospital ED visits will be established as baselines in DY2.

Rationale: According to both the rural and urban needs assessments prepared and distributed by the F. Marie Hall Institute for Rural and Community Health, Texas Tech University Health Sciences Center, Regional Healthcare Partnership 12 (RHP12) suffers from a significantly low ratio of primary care providers per population *(CN.1 – Severe primary care provider shortage, wait time, expense, lack of insurance, access to care)*. RHP12 has a population / primary care physician (PCP) ratio of 2,376 persons per PCP, compared to the state average ratio of 1,472 persons per PCP. Additionally, there is an acute shortage of registered nurses (RNs) in RHP12. The statewide average is 152 persons per RN, and the RHP12 ratio is 303 persons per RN. This shortage in both PCP and professional health care support personnel generally and inherently misdirects the population to high cost, inappropriate avenues with which to seek healthcare service; with the ED of local hospitals being the delivery source-of-choice by most. It is for the reasons denoted above: (1) an effort to increase access to primary care and (2) to deliver patient care in the appropriate setting that this project option is being selected. The below milestones and metrics have been designed to specifically address these two project aims.

The P2P Project will develop and implement an urgent medical advice call line for patient access within the regional population (to include underserved and underprivileged areas) that, if necessary and appropriate, can result in a next-day, or next-available for weekend calls, follow up appointment in the pediatric clinics of Texas Tech Physicians of Lubbock. In this manner, we can deliver the appropriate care at the appropriate location in the appropriate time. By implementing this direct contact, nurse advice line we will increase access to healthcare to our existing and potentially new patient populations. The Project will seek to develop and implement the program in a culturally-sensitive manner, thereby avoiding the cultural differences that may have de-incentivized the use of our current after-hours

automated telephone service. At its core, the Project seeks to provide urgent medical advice so that patients who need it can access it telephonically; coupled with an appropriate next day follow-up appointment, if necessary, so that access to urgent medical care is increased and avoidable utilization of urgent care and the hospital ED can be reduced. The advice line provides callers with direct access to trained nursing personnel who can address their specific health needs with an on-demand, person-to-person interactive service.

Required Core Project Components

- 1.6.2(a) - Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.

The Pediatric "Person-to-Person" Medical Advice Service program will significantly enhance and replace an existing delivery system reform initiatives (standard after hours call service) by developing processes and protocols that will be used in the framework of a direct, in-person, medical telephonic call service and that, in a timely manner triages pediatric patients who can possibly be re-directed from a hospital ED environment to an alternative, more appropriate primary care healthcare delivery site for non-emergency issues and/ or medical conditions. The Program will quarterly survey, analyze and report on users responses of the Pediatric "Person-to-Person" Medical Advice Service to ensure patient satisfaction with the services received .

- Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.

The Program will enhance linkages with Urgent Care Clinics and Emergency Departments in order to increase communication and improve care transitions for pediatric patients .

- Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

With the development of the Pediatric "Person-to-Person" Medical Advice Line program, the Program's leadership will incorporate into the Project, Process Milestone P-10 that provides for quality-specific activities that may include, but are not limited to, identifying project impacts, identifying "lessons learned", opportunities to scale all or part of the Project to a broader patient population, and identifying key challenges associated with expansion of the Project, including special considerations for safety-net populations (p-1.6.2.c).

As stated earlier, this project will also serve to address the community need of enhanced access to care as delineated in *CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, and access to care*.

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: N/A

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and in the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project positively impacts the wavier goals by assuring patients receive high quality and patient-centered care through interaction with this personal intervention, and in the most cost effective way by reducing the number of non-emergent, non-urgent healthcare delivery through hospital emergency departments (EDs). Next-day, or next-available clinic appointments provides for, in some case needed follow-up to the previous night's encounter and provides better, more appropriate access to Medicaid and the uninsured residents in our county. The combination of the "Person-to-Person" medical advice line and next-day scheduling of clinic appointments further develop and maintain a coordinated care delivery system and should improve outcomes while containing delivery cost.	**5**
Addresses Community Need(s)	This project speaks directly to the community needs of access to care, expense associated with the provision of healthcare in this highest-cost environment of hospital EDs, and wait times found in most hospital emergency rooms for non-emergent, primary medicine care; all of which are "critical need" in RHP12.	**5**
Project Scope/Size	Our current pediatric population is estimated at ~24,000 and will be the basis for this intervention/ project. We expect substantial improvement in both this targeted population and the additional patient increases that will come from active outreach and marketing of the medical advice line both from within our existing population base and outside, community marketing efforts. While hard to predict the total overall impact of this intervention; conservatively, it is likely to produce improved access and cost reduction through re-direction to more appropriate delivery sites in both current and increased patient base resulting from this intervention.	**4**
Project Investment	While not tremendously expensive on the front end, we do expect required investment to grow, primarily in human resources and equipment purchasing and associative maintenance, resulting from an increase in the department's patient base that over the years will be resulting from this project intervention.	**3**

Unique Identifier: ***084599202.1.2***	***RHP PP Reference Number: 1.6.2***	***Project Component(s):*** ***1.6.2.(a-c)***	***Establish/expand access to medical advice and direction to the appropriate level of care to reduce emergency department use for non-emergent conditions and increase patient access to health care.***
[RHP Performing Provider involved with this project – Texas Tech University Health Sciences Center-Lubbock]			*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.2*	*TBD*	***Outcome Measure (Improvement Target) Title(s):*** *TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Using ED Clinical Protocols used by several hospitals hospital councils in the region and Texas to determine appropriate and non-appropriate visits to the ED as a basis, establish clinical protocols for an urgent medical advice line. Metric 1 [P-1.1]: Clinical protocols will be developed and implemented by the Program to appropriately triage and direct care of patients. Goal: Establish clinical protocols for triage of patients utilizing the medical advice line. Data Source: Protocol documents Milestone 1 Estimated Incentive Payment (maximum amount): $343,264 **Milestone 2** [P-3]: Train nurses on clinical protocols. Metric 1 [P-3.1]: Demonstrate quantitatively the number of nurses trained on the medical advice line clinical protocols (numerator) divided by the number of nurses in the department (denominator). Goal: Ensure 100% of nurses	**Milestone 4** [P-2]: Collect baseline data by developing metrics specific to the medic al advice line to track access to pediatric patient population. Metric 1 [P-2.1]: Documentation of baseline assessment data, collected through the provider, using metrics designed to help to determine efficacy in reaching our target population. Goal: To determine the medical advice line needs and the efficacy in reaching the targeted population. Data Source: Provider documentation of baseline data collection Milestone 4 Estimated Incentive Payment: $537,148 **Milestone 5** [P-X]: Using literature, review for evidence-based practices to substantiate and test initial call volume and compare with nurse FTEs to establish appropriate nurse coverage nurse advice line operating times, provide initial patient satisfaction survey data to establish a	**Milestone 6** [P-10]: Participate in face-to-face learning meetings or seminars at least twice annually with other providers and the RHP to promote collaborative learning around shared or similar projects, with the intention of identifying and agreeing upon several improvements and publicly commit to implementing these improvements Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars. Goal: To promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Data Source: Provider documentation of semiannual meetings including meeting agendas, slides from presentations, and or meeting notes Metric 2 [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Goal: To follow through with the implementation of "raise the floor"	**Milestone 9** [P-10]: Participate in face-to-face learning meetings or seminars at least twice annually with other providers and the RHP to promote collaborative learning around shared or similar projects, with the intention of identifying and agreeing upon several improvements and publicly commit to implementing these improvements Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars. Goal: To promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Data Source: Provider documentation of semiannual meetings including meeting agendas, slides from presentations, and or meeting notes Metric 2 [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Goal: To follow through with the implementation of "raise the floor"

***Unique Identifier:* 084599202.1.2**	***RHP PP Reference number:* 1.6.2**	***Project Component(s):* 1.6.2.(a-c)**	***Establish/expand access to medical advice and direction to the appropriate level of care to reduce emergency department use for non-emergent conditions and increase patient access to health care.***
[RHP Performing Provider involved with this project – Texas Tech University Health Sciences Center-Lubbock]			*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.2*	*TBD*	***Outcome Measure (Improvement Target) Title(s):*** *TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
performing service through the medical advice line are trained on the clinical protocols. Data Source: HR Records Milestone 2 Estimated Incentive Payment (maximum amount): $343,263 **Milestone 3** [P-6]: Inform and educate patients on the nurse advice line. Metric 1 [P-6.1]: Demonstrate that the patient/ patient's guardian was contacted and received information about accessing and how to use the urgent nurse advice line. [Number of pediatric patient families informed/ educated divided by the total number of pediatric patients (targeted population)]% of targeted patients informed Goal: Via project-specific patient promotional mailers, the project will market and educate the targeted population about the availability and use of the nurse advice line with the goal of informing 100% of the patient population identified in current patient database. Data Source: Patient EHR and	patient satisfaction baseline, and establish baseline for the number of patients who utilize the nurse advice line and were given a next-day or next-available day appointment via the medical call line. Metric 1 [P-X.1]: Demonstrate and establish as a baseline the appropriate and reasonable calls per nurse (Number of patient calls per shift divided by the number of nurses staffing the nurse advice line per shift] Goal: To establish an appropriate productivity level for nursing staff per shift. Data Source: Evidence-based "best practices" documentation and results/ data from Provider's productivity testing initiative. Metric 2 [P-X.2]: Establish a baseline for patient satisfaction to be compared against improvement milestones indicated in DY4 and DY5. [Number of surveyed who access the Nurse Advice Line and find it helpful divided by the Total number of survey patient who accessed the Nurse Advice Line] Goal: To establish a patient	and "raise the bar" initiatives that improves performance across all providers. Data Source: Documentation of the improvement initiative(s) decided at the semiannual meeting and documentation that the participating provider implemented the improvement initiative(s) after the semiannual meeting. Milestone 6 Estimated Incentive Payment (maximum amount): $383,083 **Milestone 7** [I-14]: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice line. Metric 1 [I-14.1]: Demonstrate that the patients in the defined population are less likely to seek non-emergent care in the ED if an urgent medical appointment is scheduled via the Nurse Advice Line [(Number of patients in defined population who were scheduled for a follow-up next-day or next-available medical appointment via the nurse advice line divided by the Total number of	and "raise the bar" initiatives that improves performance across all providers. Data Source: Documentation of the improvement initiative(s) decided at the semiannual meeting and documentation that the participating provider implemented the improvement initiative(s) after the semiannual meeting. Milestone 9 Estimated Incentive Payment (maximum amount): $370,128 **Milestone 10** [I-14]: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice line. Metric 1 [I-14.1]: Demonstrate that the patients in the defined population are less likely to seek non-emergent care in the ED if an urgent medical appointment is scheduled via the Nurse Advice Line [(Number of patients in defined population who were scheduled for a follow-up next-day or next-available medical appointment via the nurse advice line

***Unique Identifier:* 084599202.1.2**	***RHP PP Reference number:* 1.6.2**	***Project Component(s):* 1.6.2.(a-c)**	***Establish/expand access to medical advice and direction to the appropriate level of care to reduce emergency department use for non-emergent conditions and increase patient access to health care.***	
[RHP Performing Provider involved with this project – Texas Tech University Health Sciences Center-Lubbock]				*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.2*	*TBD*	***Outcome Measure (Improvement Target) Title(s):*** *TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Provider marketing materials, mailing list & patient data base as produced through practice management software. Milestone 3 Estimated Incentive Payment (maximum amount): $343,263	satisfaction baseline Data Source: Patient Survey and Provider Analysis documentation Metric 3 [P-X.3]: Determine and establish as a baseline the number of patients utilizing the nurse call line who received subsequent next day appointments to be compared against improvement milestones indicated in DY4 and DY5. [Number of patients who utilized nurse advice line and were scheduled a next-day or next-available follow-up appointment divided by the total number of patients in the defined population] Goal: To establish a patient utilization, and reduced ED use baseline Data Source: Provider analysis and results documentation Milestone 5 Estimated Incentive Payment: $537,147		patients in defined population) minus baseline percentage established in DY3 (P-X.3)] Goal: Reduce the number of patients' likely seeking non-emergency and/ or non-urgent care from the hospital ED setting by increasing the number of next available appointment slots reserved specifically for the nurse advice line by 20% over the baseline established by Milestone 5, Metric 3 in DY3. Data Source: Provider phone and encounter records and appointment scheduling records. Milestone 7 Estimated Incentive Payment: $383,081 **Milestone 8** [I-15]: Increase Patient Satisfaction Metric 1 [I-15.1]: Demonstrate an increase in patient satisfaction results as compared to the baseline established in DY3. [(Number of surveyed who access the Nurse Advice Line and find it helpful divided by the Total number of survey patient who accessed the Nurse Advice Line) minus baseline patient satisfaction	divided by the Total number of patients in defined population) minus percentage established in DY4] Goal: Reduce the number of patients' likely seeking non-emergency and/ or non-urgent care from the hospital ED setting by increasing the number of next available appointment slots reserved specifically for use by the nurse advice line by 30% over the baseline established by Milestone 5, Metric 3 in DY3. . Data Source: Provider phone and encounter records and appointment scheduling records. Milestone 10 Estimated Incentive Payment: $370,127 **Milestone 11** [I-15]: Increase Patient Satisfaction Metric 1 [I-15.1]: Demonstrate an increase in patient satisfaction results as compared to the DY4 patient satisfaction percentage. [(Number of surveyed who access the Nurse Advice Line and find it helpful divided by the Total number of survey patient who accessed the Nurse Advice Line)

***UNIQUE IDENTIFIER:* 084599202.1.2**	***RHP PP REFERENCE NUMBER: 1.6.2***	***PROJECT COMPONENT(S):* 1.6.2.(A-C)**	***Establish/expand access to medical advice and direction to the appropriate level of care to reduce emergency department use for non-emergent conditions and increase patient access to health care.***	
[RHP Performing Provider involved with this project – Texas Tech University Health Sciences Center-Lubbock]				*TPI: 084599202*
Related Category 3 Outcome Measure(s):	*084599202.3.2*	*TBD*	***Outcome Measure (Improvement Target) Title(s):*** *TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			percentage (P-X.2)] Goal: Increase patient satisfaction with the nurse advice line by 10% over the baseline established by Milestone 5, Metric 2 in DY3. Data Source: Patient survey data specific to the use of the nurse advice line Milestone 8 Estimated Incentive Payment: $383,081	minus DY4 patient satisfaction percentage] Goal: Increase patient satisfaction with the nurse advice line by 15% over the baseline established by Milestone 5, Metric 2 in DY3. Data Source: Patient survey data specific to the use of the nurse advice line Milestone 11 Estimated Incentive Payment: $370,127
Year 2 Estimated Milestone Bundle Amount: $1,029,790	Year 3 Estimated Milestone Bundle Amount: $1,074,295		Year 4 Estimated Milestone Bundle Amount: $1,149,245	Year 5 Estimated Milestone Bundle Amount: $1,110,382
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,363,712				

Project Option 1.9.1 – Expand high impact specialty care capacity in most-impacted medical specialties

Unique Project ID: 084599202.1.3

Performing Provider: Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)

Provider: The Texas Tech Physicians of Lubbock, Department of Psychiatry is currently made up of nine (9) attending/ faculty practitioners and up to sixteen (16) resident positions. Combined, these practitioners see more than 5,200 clinic and inpatient visits annually. This department of the TTUHSC School of Medicine is a significant provider of behavioral, mental, substance abuse, marriage and family therapy, and grief counseling services.

Intervention(s): The project will develop, implement, and market a professional certification curriculum in psychiatry and mental health for Physician Assistants and Nurse Practitioners.

Need for the project: According to the RHP12 Regional Needs Assessment, access to qualified psychiatric services is at a critical state in the region. Less physician candidates are entering this specialty practice. The project's sole focus will be on mid-levels as a means of closing the gap and increasing access to this vital health specialty. This particular need was categorized as "critical" for RHP12.

Target population: The department's payer mix includes approximately 25% Medicaid and approximately 10% of uninsured and underinsured. For the period September 2011 – August 2012, the Texas Tech Physicians of Lubbock, Department of Psychiatry had a professional staff of thirteen (12) providers – one (1) of which was a Physician's Assistant (PA). As a group, the psychiatry department delivered behavioral/ mental health services to 960 patients through 6,577 patient encounters. These services were provided in both the inpatient and office settings. Of the over 960 patient, 438, or approximately 46% were Medicaid and Uninsured patients which would be an expected percentage going forward. All patients in need of psychiatric services, both current and future patients of this department, will benefit dramatically from the project's focus on the establishment of specialized psychiatric training for mid-level providers.

Category 1 expected patient benefits: This project is specifically designed to be focused on increasing the numbers of psychiatry specialist-trained, mid-level providers to counteract the growing need for greater access to behavioral, mental, substance abuse, marriage and family therapy, and grief counseling health services. Additionally, the program seeks to re-direct the present course of access away from hospital emergency departments; often the initial contact/ access to mental health-related services.

Category 3 outcomes: While not totally developed, this project's Category-3 outcomes seeks to increase the access to psychiatric care needs, shorten appointment times, and reduce the use of hospital emergency rooms for access; all of which are so prevalent in the region, as indicated in the region's needs assessment.

Project Option 1.9.1 – Expand high impact specialty care capacity in most-impacted medical specialties

Unique Project ID: 084599202.1.3

Performing Provider: Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)

Project Description:

Texas Tech University Health Sciences Center (TTUHSC) Department of Psychiatry proposes to develop a behavioral health certification program designed specifically for the certifying of Nurse Practitioners and Physician's Assistants (Mid-Level Practitioners)

Texas Tech Physicians of Lubbock, Department of Psychiatry is dedicated to providing quality mental health care to Lubbock and surrounding communities. According to the Regional Health Partnership 12 Rural and Urban counties reports prepared by the F. Marie Hall Institute for Rural and Community Health at TTUHSC, it is very obvious that expanded access to mental and behavioral health is an issue for Region 12 (F. Marie Hall Inistitute for Rural and Community Health, 2012). In order to keep up with the growing demand for services, TTUHSC Psychiatry proposes to develop a training program for Mid-level providers to enhance their clinical skills in the area of Psychiatry. The program will be a certificate program with curriculum developed by the Department of Psychiatry, TTUHSC School of Medicine and in conjunction with the Texas Tech University Health Sciences Center School of Nursing and Texas Tech University Health Sciences Center School of Allied Health. TTUHSC will work with other local institutions such as the Montford Psychiatric Prison Hospital, StarCare (formerly known as Lubbock Regional Mental Health Mental Retardation), Covenant Medical Center, Texas Tech University Student Health Services, and Community Health Center of Lubbock. The certificate program will prepare Mid-levels to take the National Commission on Certification of Physician Assistants (NCCPA) certification exam for Physician Assistants and the American Nurses Credentialing Center (ANCC) certification exam for Nurse Practitioners. According to the needs assessment prepared especially for the Texas Healthcare Transformation and Quality Improvement Program, RHP12 suffers from a shortage of Psychiatric, mental, behavioral, and substance abuse related healthcare professionals (F. Marie Hall Institute for Rural and Community Health, 2012). As referenced in the F. Marie Hall Institute of Rural and Community Health Needs Assessment Report for the Regional Healthcare Partnership Region 12, the following counties responded the following major needs in mental and behavioral health:

County	**Concern**
Dawson County	Need for mental health services
	Need for drug and alcohol treatment services
Garza County	Need for drug and alcohol treatment services
Ochiltree County	Need for mental health services
	Need for drug and alcohol treatment services
	Need for a psychiatric treatment facility
Dawson County	Need for mental health services
	MHMR is receiving budget cuts, therefore less to help people with mental health
	Need for drug and alcohol treatment services

Hutchinson County	Need for mental health services
Lamb County	Need for mental health services

This program seeks to specifically address community need *CN.2 – Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact,* which according to the region's needs assessment is categorized as a "Critical Need." Many of the counties in RHP12 have no access to psychiatric, mental, behavioral, or substance abuse care (F. Marie Hall Inistitute for Rural and Community Health, 2012). This is demonstrated by the report prepared by Health Professions Resource Center, Center for Health Statistics, Texas Department of State Health Services, March 25, 2011 which indicates that 39 counties in Region 12 are designated as shortage areas for mental health professionals. It is also demonstrated with the responses from the F. Marie Hall Institute of Rural and Community Health Needs Assessment Report for the Regional Healthcare Partnership Region 12, as outlined in the Rationale and Goals section of this proposal. More than half of all current psychiatrist are 55 years or older and retiring from practice. Fewer medical school graduates are showing interest into going into psychiatry. The demand for mental health services is expected to increase by 19% by 2020. We believe the proposed project will specifically address the above challenges. Expand specialty behavioral healthcare to the region through the development and delivery of curriculum and specialized clinical rotation training in psychiatry for Mid-level providers that, for the graduates of the Program will culminate into the successful completion of conferring national certifications in behavioral health from their respective licensing and certification governing bodies and inspiring Mid-level Providers to filling the gap between supply and demand.

We expect to increase the number of mid-level providers trained in psychiatry, therefore, increasing access to mental health services for patients and expand specialty care access for psychiatry. We recognize that psychiatric care is underserved in Region 12 (F. Marie Hall Inistitute for Rural and Community Health, 2012), and will expand the number of providers who can diagnosis and treat such conditions, creating more behavioral healthcare access. As mentioned before, 39 counties in Region 12 are designated as shortage areas for mental health professionals. Our 5-year expected outcome of increasing the numbers of behavioral health trained practitioners, and thus expanding access to a critical services can be achieved by providing a more focused and robust curriculum, along with additional rotations and training sites for the mid-level providers, from which we will increase the success rates of mid-levels taking board certification in psychiatry; and thus establish a more comprehensive and expanded provider base from which to draw behavioral health services. The program will provide an increased exposure to patients, thereby, making mid-levels more comfortable to treat mental and behavioral illnesses. Workforce enhancements for obtaining board certification for Mid-level Providers include:

-Increased compensation
-Enhanced career mobility
-Elevated practice standards
-Confidence in delivering a higher quality level of patient care

For the period September 2011 – August 2012, the Texas Tech Physicians of Lubbock, Department of Psychiatry had a professional staff of thirteen (12) providers – one (1) of which was a Physicians Assistant (PA). As a group, the psychiatry department delivered behavioral/ mental health services to 960 patients through 6,577 patient encounters. These services were provided in both the inpatient and office settings. Of note, the one PA was responsible for 2,288, or approximately 35% of all patient encounters during this time period. Of the over 960 patient, 438, or approximately 46% were Medicaid and Uninsured patients which would be an expected percentage going forward. According to published studies and analysis (Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27 and U.S. Census Bureau Population Estimates by Demographic Characteristics. Table 2: Annual Estimates of the Population by Selected Age Groups and Sex for the United States: April 1, 2000 to July 1, 2004 (NC-EST2004-02) Source: Population Division, U.S. Census Bureau Release Date: June 9, 2005. http://www.census.gov/popest/national/asrh/ , it has been suggested that 1 in 4 people have some form of psychological, behavioral, and/or additive disorders that is confounding primary care practices/ providers across this region, the state, and the country. If a specialty practice PA can deliver psychiatry-specific health services through 2,288 patient encounters over the course of a year (as indicated above); this would suggest that through the care of a primary care provider(s) in RHP12 that potentially over 9,000 primary care patient encounters annually could be served and benefit from psychiatric/ behavioral/ additive interventions from a certified provider. Of the projected 9,000 primary care patient encounters, in excess of 4,100 primary care patient encounters would likely be to Medicaid beneficiaries and the uninsured.

Starting Point/Baseline: Currently, Mid-level provider students receive a six week required rotation in psychiatry prior to their graduation. However, this does not provide them with enough knowledge to effectively or confidently treat behavioral health issues, nor will this provide enough training to qualify for behavioral health specialty certification. Therefore, the baseline for number of participating Mid-level trainees begins at zero (0) in DY2.

Rationale: Demand for psychiatrist is growing faster than any other medical specialty. More than half of all current psychiatrist are 55 years or older and retiring from practice. Fewer medical school graduates are showing interest into going into psychiatry. The demand for psychiatric care goes up in a recessive economy. Therefore, the demand versus the supply could reach crisis level soon. According to a survey conducted locally by the TTUHSC – Lubbock, Department of Psychiatry, the current wait times (as of September 2012) for patients seeking appointments for behavioral health services are:

- StarCare (Formerly Lubbock Regional Mental Health Mental Retardation) -18 months
- TTUHSC Department of Psychiatry –no new patient access, 3 weeks for returning patients
- Texas Tech Student Health Services-3 weeks (TTU Student population only)
- Community Health Center of Lubbock- 2 months

This survey supports the same notion as discovered in the RHP12 Needs Assessment; specifically, CN.2, which describes the problem needing addressing as, “lack of mental health services, inability to get an appointment, lack of insurance, and need to use the emergency rooms for initial contact.”

The demand for mental health services is expected to increase by 19% by 2020 (Merritt Hawkins, Inc. , 2010). Due to an increasing number of patients in RHP12 and the need for more mental health services, ***coupled with a growing shortage of mental health providers***, the focused training of Mid-level providers (Physician Assistants and Nurse Practitioners) provide both a reasonable and acceptable additional to the traditional MD & DO focus to expanding access to mental health care for underserved populations (American Academy of Physician Assistants, 2007). Mid-level Providers are capable and authorized to conduct psychiatric evaluations, initiate treatment, perform individual and group psychotherapy, write orders, make rounds, evaluate and treat general medical conditions in psychiatric patients, and oversee alcohol and drug detoxification (St. John, 2006). The Needs Assessment also shows that 39 counties in Region 12 are in a federal designated mental health professional shortage area as of March 25, 2012 (F. Marie Hall Institute for Rural and Community Health, 2012). It is very apparent there is a need for expansion of mental and behavioral health specialists for the impacted Region 12. Due to the significant need of mental and behavioral healthcare providers in the RHP Region 12 area, we will work with rural and frontier area providers to allow rotations through their clinics. This will expose the trainees to these communities, and thereby increasing the likelihood they would service these areas. This will increase access for the most severely impacted areas of our region.

Required Core Project Components:

- 1.9.1(a) - Identify high impact/most impacted specialty services and gaps in care and coordination

At the heart of the Program, the Program's leadership will continuously seek to identify the greatest gaps in the delivery of behavioral health care services. Every endeavor will be made to attempt to bridge the gap of behavioral health patient access and coordination (P-1.9.1.a). One of the major sources of gap data and information that the program's leadership will use for ongoing monitoring and focus will be the annual report produced by the F. Marie Hall Institute for Rural and Community Health.

- 1.9.1(b) - Increase the number of residents/trainees choosing targeted shortage specialties

The Program will increase the number of behavioral health trainees with the development and implementation of a certificate training program designed specifically for Physician Assistants and Nurse Practitioners that will prepare these mid-level practitioners to be successful on their respective licensing organization's nationally-recognized specialty practice certifications (P-1.9.1.b).

- 1.9.1(c) - Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)

Through this training and preparatory certification program, participants will rotate through various clinical settings, many that will support access to the behavioral health specialist in underserved market and areas. This exposure will likely have the secondary consequence of recruiting, and in some cases retaining newly-minted behavioral health specialist to these areas (P-1.9.1.c).

- 1.9.1(d) - Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Additionally, the Programs' leadership will invoke Milestone P-21 so that improvement opportunities can be identified and acted upon in a timely fashion. These quality-specific activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the Project to a broader patient population, and identifying key challenges associated with expansion of the Project, including special considerations for safety-net populations (P-1.9.1.d).

Related Category 3 Outcome Measure(s): TBD

Relationship to Other Projects: N/A

Relationship to Other Performing Providers' Projects and Plan For Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and in the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project intervention will substantially improve the healthcare infrastructure for the region by developing providers to reduce the gap between demand and supply for this particularly-critical healthcare service need. This project will address, in a positive way, the excess cost associated with behavioral, mental, and substance abuse as access to these service modalities typically involve the use of hospital emergency rooms; thereby improving outcomes while containing cost growth. While the project does not particularly single out its positive impact on Medicaid and or the uninsured residents; these within the region's patient mix will certainly be impacted in a positive manner.	**4**
Addresses Community Need(s)	This project is intended to specifically address one of the two needs, as determined by the RHP12 Needs Assessment, categorized as 'Critical" in nature. Specifically, CN.2 (in summary), as a description of the problem needing to be addressed, states, "lack of mental health services, inability to get an appointment, lack of insurance, and need to use ER for initial contact/ access." This program will continuously introduce new, certified, Mid-level Providers into the healthcare marketplace to relieve and close the gap between supply and demand; thereby increasing access to this much needed specialty care while reducing the cost of delivery by reducing the numbers of patients who seek access to behavioral health, mental health , and substance abuse services through hospital emergency rooms. This program will deliver a level of confidence in treating behavioral, mental, and substance abuse issues, to Mid-level graduates previously unavailable with current Mid-level curriculum, training, and patient exposure in behavioral health issues.	**5**
Project Scope/Size	Medium impact will be achieved initially, but over the long term, many new healthcare providers will be trained and graduated through this certification program that will reach a higher and higher percentage of the population needing access to behavioral health, mental, and substance abuse medical services. Healthcare cost will continue being positively impacted as more behavioral health providers are providing timely interventions in much less costly environments as compared to a hospital emergency room and/ or associative hospitalizations.	**3**
Project Investment	Project medium project investment characterized primarily with the addition of new faculty and the time to implement through curriculum development and the development of clinical rotation agreements.	**3**

084599202.1.3	***1.9.1***	***1.9.1.(A-D)***	***Expand high impact specialty care capacity in most-impacted medical specialties***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI:084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.3*	*TBD*	*TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Development & execution of clinical rotation contracts, development, & implementation of program policies and procedures, clinical protocols, and requirement for additional training program faculty. Metric 1 [P-X.1]: Prepare and execute contracts with community health providers to allow trainees to rotate through the facilities for clinical exposure and training. Goal: Establish/ expand clinical rotation site for trainees. Data Source: Executed contracts between rotation facilities and TTUHSC Department of Psychiatry Metric 2 [P-X.2]: Policies and procedures will be established for the requirements for acceptance into the program, rotations within the facilities, development of didactic presentations, and standards of care protocols. Goal: Establish program policies & procedures. Data Source: Completed program policy and procedures manual	**Milestone 2** [P-14]: Expand psychiatric training program for Mid-level providers. Metric 1 [P-14.1]: Acceptance and addition of new trainees to the Program. Initially, the program will start with 2 trainees with the goal of adding 2 new trainees to an academic year – for a maximum of 6 trainees per academic year. This DY3 metric will establish the trainee baseline for the Program and be used for improvement comparison purposes in future demonstration years. [Number of accepted mid-levels divided by the number of applications received]. Goal: To establish baseline for number of trainees (x2) Data Source: Training program documentation, including program applications for admissions. Metric 2 [P-14.2]: Hire an additional 1FTE precepting behavioral health faculty member necessary to support the additional educational requirements resulting from the addition of the behavioral		**Milestone 4** [I-31]: Increase Mid-level psychiatry training or rotations. Metric 1 [I-31.1]: The Mid-level training program will show a 100% increase (from 2 to 4 trainees) in the behavioral health Mid-level class size as compared to the DY3 class size. [Number of enrolled trainees in current year (DY4) minus the number of enrolled trainees in the previous year (DY3) divided by the number of enrolled trainees in the previous year (DY3).] Goal: Continue increasing the class size of the Mid-level Behavioral Health Training program (x2). Data Source: Documented enrollment by class by year. Milestone 4 [I-31] Estimated Incentive Payment *(maximum amount):* $507,020 **Milestone 5** [P-21]: Participate in face-to-face learning (i.e. meeting or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.	**Milestone 6** [I-31]: Increase Mid-level psychiatry training or rotations. Metric 1 [I-31.1]: The Mid-level training program will show a 50% increase (from 4 to 6 trainees) in the behavioral health mid-level class size as compared to the DY4 class size. Six (6) trainees per academic year will constitute a full class for the program. [Number of enrolled trainees in current year (DY5) minus the number of enrolled trainees in the previous year (DY4) divided by the number of enrolled trainees in the previous year (DY4). Goal: Continue increasing the class size of the Mid-level Behavioral Health Training program to = 6 total representing a full program class size. Additional hiring of 1 FTE precepting faculuty to maintain trainee: precepting faculty ratio of 2:1 Data Source: Documented enrollment by class by year and faculty list. Milestone 6 [I-31] Estimated Incentive Payment *(maximum*

084599202.1.3	***1.9.1***	***1.9.1.(A-D)***	***Expand high impact specialty care capacity in most-impacted medical specialties***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI:084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.3*	*TBD*	*TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 3 [P-X.3]: Additional precepting faculty will be hired in DY2 to develop didactics for the program and provide supervision to the students in the program. Trainee: Precepting Faculty will be maintained at a 2:1 ratio to ensure richness of the program. Goal: Hiring of additional precepting faculty to support new Mid-level Certification Training Program. This goal will be met with the hiring of 1 FTE for the program's initial 2 trainees. Data Source: HR documents and faculty lists. Milestone 1 [P-X] Estimated Incentive Payment *(maximum amount):* $908,638	health certification program for Mid-level providers. Goal: Maintain appropriate faculty to support growing psychiatric training program. Trainee:Precepting Faculty = 2:1. Data Source: HR documents, faculty lists, or other documentation Milestone 2 [P-14] Estimated Incentive Payment *(maximum amount):* $473,954 **Milestone 3** [P-21]: Participate in face-to-face learning (i.e. meeting or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.1]: Participate in semi-annual face-to-face collaborative meetings with other providers. Goal: Promote continuous learning and exchange between providers. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting		Metric 1 [P-21.1]: Participate in semi-annual face-to-face collaborative meetings with other providers. Goal: Promote continuous learning and exchange between providers. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Metric 2 [P-21.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Goal: Discovery and implementation of "raise the floor" improvement initiatives resulting from semi-annual meetings. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 5 [P-21] Estimated Incentive Payment (maximum	*amount):* $489,875 **Milestone 7** [P-21]: Participate in face-to-face learning (i.e. meeting or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.1]: Participate in semi-annual face-to-face collaborative meetings with other providers. Goal: Promote continuous learning and exchange between providers. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Metric 2 [P-21.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Goal: Discovery and implementation of "raise the floor" improvement initiatives resulting from semi-annual meetings. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the

084599202.1.3	***1.9.1***	***1.9.1.(A-D)***	***Expand high impact specialty care capacity in most-impacted medical specialties***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI:084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.3*	*TBD*	*TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	notes. Metric 2 [P-21.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Goal: Discovery and implementation of "raise the floor" improvement initiatives resulting from semi-annual meetings. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 3 [P-21] Estimated Incentive Payment *(maximum amount):* $473,953		amount): $507,020	floor" improvement initiative after the semiannual meeting. Milestone 7 [P-21] Estimated Incentive Payment (maximum amount): $489,874
Year 2 Estimated Milestone Bundle Amount: $908,638	Year 3 Estimated Milestone Bundle Amount: $947,907		Year 4 Estimated Milestone Bundle Amount: $1,014,040	Year 5 Estimated Milestone Bundle Amount: $979,749
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,850,334				

Project Option: 1.3.1 Implement/enhance and use chronic disease management registry functionalities
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.1.1

Project Description:

- **Provider:** University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.
- **Interventions(s):** This project will be to select and implement a chronic disease registry, into which each patient's data will be entered. The project will include the training of selected staff in the hospital and selected clinics on the use of the registry. A patient population with specific chronic conditions (examples: diabetes, congestive heart failure, hypertension, and asthma) will be selected and the trained staff will utilize the tools within the chronic disease registry for patient contacts and education. The project will work towards improved self-management by patients and ultimately improved outcomes. Using PDCA (plan, do, check, act), staff will re-assess education and interventional efforts making changes as necessary to reach the desired goals. Ultimately, when the process is refined, the use of the chronic disease registry will be expanded to additional clinics.
- **Need for the project:** Chronic conditions were identified in the community needs assessment as an urgent issue. Targeted conditions like congestive heart failure, hypertension, asthma, and diabetes are widespread in our community and region. To properly manage these patients, intervention beyond the typical outpatient visit is necessary. The registry allows providers to target the overall health of a disease population, look for outliers, and education beyond the visit to achieve goals outlined above. By utilizing the registry, the patient has a better chance of addressing the medical needs and preventive medicine necessary to better control their chronic condition. The result is that the patient may avoid more serious spells of illness and reduce the overall care that they may need.
- **Target population:** The population of this project will be patients admitted to University Medical Center, diagnosed with a particular chronic disease. This population will include 100 % Medicaid and unfunded patients. The estimated annual number of Medicaid/Uninsured patients seen in our hospital with a chronic disease (based on 2012 admissions) is 4100.
- **Category 1 or 2 expected patient benefits:** The expected patient benefit of this project is for 50 % (or 2000) patients to be contacted through use of the registry by DY 4, and for 75% (or 3000) patients to be contacted by DY 5.
- **Category 3 outcomes:** IT-3.1 30 day readmission rate (all cause – patients). Our goal is to reduce readmissions for the identified population.

Project Option: 1.3.1 Implement/enhance and use chronic disease management registry functionalities
Performing Provider: University Medical Center/137999206
Unique Identification Number: 137999206.1.1
Project Components: 1.3.1.a-d

- **Project Description – Project 1.3.1:** A chronic disease registry is an information system designed to support care mgt. The main purpose is to assist physicians and other providers as they care for their patients with chronic diseases, across the continuum of care. Examples of assistance to be gained from the registry include progress reports to be reviewed by registry coordinators, and "rule based" prompts used to prioritize interventions and provide education. Ambulatory providers of UMC Health System clinics (PNS) PNS and Texas Tech (TTU), within primary care sites, will participate. A coordinator or coach will be placed within a primary care setting to facilitate the most efficient provider-patient interaction. The coach will work closely with patients and providers, helping patients to engage in their own care, beyond the clinic visit which is typically limited in time. We have seen initial success using the coach model, specific to heart failure patients. It is estimated we will start with 2-3 ambulatory care (primary care) clinics. Through education and the building of positive relationships between coach and patient, patients will be encouraged to some responsibility for their care and treatment, ranging from diet and activity to healthy habits.

- The process of implementation will be as follows:
    - Select a chronic disease registry, into which each patient's data will be entered. UMC will purchase and install this registry as a repository for patient data, specific to select chronic conditions for patients admitted to UMC (examples: diabetes, congestive heart failure)
    - Train all staff in selected clinics on the registry…patient data management (prior to, during and after patient visits) and report generation (to reflect progress made). The registry prompts patient contacts and education, toward improved self-management by patients and ultimately improved outcomes. The registry will be utilized as part of the structure for the Category 2 Project, Expand Chronic Care Mgt Models.
    - Using PDCA (plan do check act) re-assess educational and interventional efforts; amend as needed to reach desired goals. Through this process, performance (quality) improvement will be actively pursued, toward goals of reduced readmissions and overall improved outcomes, and lessons learned, impacts made.
    - Expand registry utilization to additional clinics.

  The population of this project will be patients seen in the acute care setting, diagnosed with a particular chronic disease. Thus, the population will include both funded and under-funded patients of Lubbock County.

- **Project Goals:** Our goals are to engage and educate patients; to facilitate more efficient clinic interactions; and as a result, to improve patient compliance with instructions. Achievement of these goals will be based on volume of patients within the registry, utilization of the registry by providers, and achievement of logistical elements such as production of and analysis of registry reports – by examining aggregate caseload of chronic patients to discover outliers, providers can target those patients who have lagged behind and need additional assistance to improved health. The ultimate goal is to improve patient health while reducing cost via lowered hospital admissions and readmissions.
- **Challenges:** The primary challenge will be to engage patients and families to the extent that patients will desire to improve, to the extent that they change habits, adjust lifestyle and prioritize the needed steps toward better health. Many basic factors stand in the way…transportation, financial resources for medication and physician appointments, and family pressure to avoid dietary or other restrictive prescriptions. This is why the coach has to build a trusting relationship with his or her patients.
- **5-Year Outcome:** The 5-year outcome is the development of a robust disease registry, utilized by most if not all primary care clinics within the health system, and a corresponding decrease in readmission rates, below expected level.
- **Relationship to Regional Goals: :** The regions primary goals are to be responsive to the issues identified in the community needs assessment and to achieve progress towards the triple aim goals of improving the patient experience including quality and satisfaction, improving the health of populations and reducing the per capita cost of care. This project will contribute towards improving the quality and satisfaction of the patient and reduce the associated cost of providing care by providing evidenced based care for those with chronic conditions. The successful implementation of this project will provide additional data to health care providers that will enhance the coordination and completeness of treatment for chronic conditions. This project directly impacts CN.1 as it relates to cost of care, CN.3 and care of the unfunded, and CN.5 and care for those with chronic conditions.
- **Starting Point/Baseline:** Number of patients enrolled in registry: 0. Number of providers trained/utilizing registry: 0. Estimated number of patients with potential for being enrolled in the registry is 4100 (based on 2012 admissions).
- **Rationale:** Chronic conditions are expensive to manage both in the clinic and in regard to hospital readmissions. Targeted conditions like congestive heart failure (CHF) are widespread in our community. According to Emory Healthcare, 550,000 new cases of CHF are diagnosed each year. CHF patients readmit frequently for symptom relief. The number of Americans with diagnosed diabetes, as another high-volume chronic condition, is projected to increase 165% from 11 million in 2000 to 29 million in 2050, according to Diabetes Care Journal. To manage these patients, intervention is needed beyond the typical inpatient visit. A registry of patients – per diagnosis – will give both the provider and the coach/coordinator assistance in managing these patients, individually and in comparison to others. The registry allows providers to target the overall health of a disease population, look for outliers, and educate beyond the visit, to achieve goals outlined above. This project addresses two community needs identified. Both CN.1 and CN.5 are related by providing the right level of interaction between the patient and the care giver. By utilizing the registry, the patient has a better chance of addressing the medical needs and preventive medicine necessary to better control their chronic condition. The result is that the patient may avoid more serious spells of illness and reduce the overall care that they may

need. University Medical Center does not currently have a disease management registry or the technology to provide these services. This will be a new initiative for the facility.

Implementation of required core project components:

a. *Enter patient data into unique chronic disease registry*: Once a disease registry has been selected, an interface will be installed to transfer inpatient discharges into the registry. The registry will then be manipulated to produce meaningful data, per chronic disease, to help staff manage those patients, with ultimate goal of reduced hospital readmissions.
b. *Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need*: The real value of the disease registry will be the "work list" it will produce – which will provide staff their assigned tasks – which chronically ill patients to contact by telephone, letter or other means, in an effort to proactively "get ahead of their symptoms" and thus assist them in their care, reducing hospital readmissions. The registry can risk stratify patient work load by indicating which patients are most "at risk" across a variety of diseases.
c. *Use registry reports to develop and implement targeted QI plan*: Registry reports will be produced for each disease process (hypertension for example), designed to indicate patients at risk, patients needing follow up care, and patients needing assistance (pharmacy, transportation, etc.). Again, these reports will be used to augment case managers' work list, moving those most at risk to the top of the priority list. A QI plan will be developed based on a) the baseline health status and readmission status of the selected chronic disease and b) the goals associated with category 3 outcomes.
d. *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations of safety-net populations*: Performance (quality) Improvement methodology will be applied to this project. For instance, we may use Plan, Do, Check, Act (PDCA cycle) to identify baseline, improvements noted, revisions to our outreach/education efforts, and ultimately goals achieved.

Milestone P-1, identify one or more target patient populations diagnosed with selected chronic disease will be utilized as a starting point after the implementation of the registry, the target population will be unfunded and Medicaid patients with a chronic disease and admitted to UMC. Process Milestone P-3, develop cross-functional team to evaluate the registry program is important because this is where the integrity of the program and as a result, the usefulness of the program will be determined. Process Milestone P-6, conduct staff training on populating and using registry functions is critical to the success of this project and the related Category 2 project. Staff's knowledge of the system and its capabilities will ultimately be a limiting factor on how effective the registry can be in addressing care for chronic conditions. Staff must have the education to now only understand what the registry does, but also how it can be used to enhance the care of the patient. Improvement Milestone I-16, increase the number of patient contacts recorded in

the registry relative to baseline rate. More patient contacts will allow practitioners to reach out to more patients who may have gaps in care. This will allow for better management of care by both the patient and providers.

- **Related Category 3 Outcome Measure(s):**
  Domain: OD-3 Potentially Preventable Re-admissions – 30 Day Readmission Rates
  IT-3.1 30 day readmission rate (all cause – patients)
  The implementation and utilization of a disease management registry will allow care providers some of the tools to help the long-term care of patients. The identification of a chronic condition is often triggered by an acute event cared for within a hospital. Patients with chronic conditions will be captured in the registry as soon as possible. Through chronic condition management it is believed that the need for admission and readmissions into an acute care setting can be reduced.
- **Relationship to other Projects:** This project relates to 137999206.2.1 2.2 Expand Chronic Care Management Models and 137999206.1.2 1.10 Enhance Performance Improvement and Reporting Capacity. The disease management registry will be the backbone of the technology necessary to implement the Expand Chronic Care Management Models and will also be utilized to address ongoing Performance Improvement initiatives. The new approaches to improving UMC's response to issues identified that will be a part of the Enhance Performance Improvement and Reporting Capacity project will be incorporated in this project as well.
- **Relationship to Other Performing Providers' Projects in the RHP:** N/A
- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to-face meetings, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	A disease registry provides an analytical platform with evidence based guidelines to drive decision making at the point of care, and support coordination of care (and education) for patient outreach (by coach) and chronic management (by a provider). It is through this analysis and trigger based reminder/education/intervention that the Triple Aim can be achieved. Interjecting a coordinator/coach increases the care team's ability to provide patient-centered care. Reducing unnecessary visits, tests, and specifically readmissions, reduce cost and enhance patient health (admissions can lead to hospital acquired conditions). As a point of reference, a single inpatient stay (readmission) for CHF (DRG 291,92,93) will cost UMC between $4500 and $5500 (3 day stay).	**1-5**
Addresses Community Need(s)	The Advisory Board, through its product CRIMSON, as an example as seen a tremendous "moving of the dial" in facilities like Memorial Hermann in Houston. Length of stay and readmission rates both improved. UMC is similar to Hermann as a teaching hospital within a competitive market. Per the RHP 12 Needs Assessment Survey, 25% of rural counties reported a household member with some form of heart disease; the incidence in Lubbock of heart attack or angina is 7.1% in comparison to nationally at 4%. A disease registry is the first step - a foundation for managing chronic conditions like those mentioned in the Needs Assessment. Education of patients regarding diet, self-care, exercise, smoking cessation, etc. are absolutely essential and simply cannot be done effectively without the structure a registry will provide.	**1-5**
Project Scope/Size	This project is targeted (specific diagnosis groups) but is effective in scope. Based on data from 2012, approximately 4100 patients with either Medicaid or no insurance were admitted with a chronic disease. These diagnoses and the resulting readmissions cause a sizeable financial burden on hospitals, specific to Medicaid or self-pay patient volume. Again, the disease registry is foundational; therefore it is as big as other projects being submitted, in regard to impact.	**1-5**
Project Investment	Depending on how far this project is expanded, over time….the investment will encompass both software and personnel.	**1-5**

137999206.1.1	1.3.1	1.3.1.a-d	Implement/enhance and use chronic disease management registry functionalities
University Medical Center		**137999206**	
IT-3.1 All Cause 30 Day Readmission Rate	**IT-3.1**	**137999206.3.1**	**All Cause 30 Day Readmission Rate**
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	DY 5 (10/1/2015-9/30/2016)
Process Milestone 1: P-1 Identify one or more target patient populations diagnosed with selected chronic disease. **Metric: P-1.1** Documentation of patients to be entered into registry. **Baseline/Goal:** There are currently no patients tracked in a disease management registry, and approximately 4100 possible patients to track (based on 2012 discharges). The goal is to identify at least two patient populations with chronic conditions to track in the registry, and to enter 100% of patients in the registry **Numerator:** Number of patients entered into the registry with target condition; **Denominator:** Total number of patients with the target condition; **Data source:** Electronic health record. **Estimated Milestone 1 Incentive Payment:** **$2,555,782**	**Process Milestone 2: P-3:** Develop cross-functional team to evaluate registry program **Metric: P-3.1:** Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program **Baseline/Goal:** There is currently no team in place to evaluate the registry. The goal is to assemble an team of providers to effectively manage and utilize the registry. **Numerator:** number of personnel assigned to enter the registry **Denominator:** total number of personnel **Data source:** Team roster and minutes from team meetings **Estimated Milestone 2 Incentive Payment:** **$1,394,111** **Process Milestone 3: P-6:** Conduct Staff training on populating and using registry functions **Metric P-6.1:** Documentation of training programs and list of staff members trained, or other similar documentation **Baseline/Goal:** There is currently no training program for utilization of the registry. The goal	**Improvement Milestone :** Increase the number of patient contacts recorded in the registry relative to baseline rate. **Metric: I-16.1** Total number of in-person and virtual (including email, phone and webbased) visits, either absolute or divided by denominator. **Baseline/Goal:** The goal is to increase the number of patient contacts relative to the baseline rate of zero by 50% or 2000 patients. Patient contact will be in person, via mail, or via phone. **Numerator:** Number of patient contacts **Denominator:**Number of targeted patients in the registry **Data Source:** registry **Estimated Milestone 4 Incentive Payment:** **$2,796,326**	**Improvement Milestone I** Increase the number of patient contacts recorded in the registry relative to baseline rate. **Metric: I-16.1** Total number of in-person and virtual (including email, phone and webbased) visits, either absolute or divided by denominator. **Baseline/Goal:** The baseline will be that at least 50% or 2000 of patients in registry will be contacted by coach, goal is to improve to 75% or 3000 patients. Patient contact will be in person, via mail, or via phone **Numerator:** Number of patient contacts **Denominator:** Number of targeted patients in registry **Data Source:** Registry report **Estimated Milestone 5 Incentive Payment:** **$2,310,008**

137999206.1.1	1.3.1	1.3.1.a-d	Implement/enhance and use chronic disease management registry functionalities
University Medical Center		**137999206**	
IT-3.1 All Cause 30 Day Readmission Rate	**IT-3.1**	**137999206.3.1**	**All Cause 30 Day Readmission Rate**
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	DY 5 (10/1/2015-9/30/2016)
	is to develop education utilizing evidence-based care and processes to maximize the effectiveness of the registry. **Data Source:** HR or training program materials **Estimated Milestone 3 Incentive Payment: $1,394,110**		
DY 2 Estimated Milestone Bundle Amount: $2,555,782	DY 3 Estimated Milestone Bundle Amount: $2,788,221	DY4 Estimated Milestone Bundle Amount: $2,796,326	DY5 Estimated Milestone Bundle Amount: $2,310,008
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):$10,450,337			

Project Option: 1.6.2 Establish/Expand Access to Medical Advice and Direction to theAppropriate Level of Care to Reduce Emergency Department Use for Non-Emergent Conditions and Increase Patient Access to Health Care
Performing Provider: University Medical Center - 137999206
Unique Project ID: 137999206.1.2
Project Components: 1.6.2.a-c

Provider: University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.

Intervention: This project will implement a Call Center to provide patient access to nurses over the phone that can help them decide the best option to obtain medical treatment. This will decrease the utilization of the Emergency Department (ED) for semi-urgent and non-urgent care.

Need for the Project: UMC experiences thousands of patients annually who seek semi-urgent or non-urgent care from the ED. The people in these two categories who have Medicaid or are non-funded have limited options to care advice and select the ED by default. Emergency Department care is an expensive option for less than urgent medical problems and waiting long waits in the ED waiting room is not in the best interest of the patient.

Target Population: The population for this project will be Medicaid and non-funded patients presenting to the ED who are categorized as a semi-urgent or non-urgent. The volume of semi-urgent and non-urgent patients being triaged by the UMC EC in 2012 was 21,780. Seventy one percent (15,513)are Medicaid or non-funded.

Category 1 expected patient benefits: The Call Center project will decrease Medicaid and non-funded patients seeking semi or non-urgent care in the ED. The expected patient benefit is education/info provided to 3,500 patients in DY2, DY3 our goal is to have at least 1,550 or 10% of targeted population access nurse advice line, DY4's goal is 20% or 3,100 accessing, DY5's goal is 25% or 3,500 accessing.
Category 3 outcomes: IT-9.2 (ED appropriate utilization) Our goal is to reduce the Medicaid and non-funded volume of patients who are seeking semi-urgent and non-urgent care in the Emergency Department.

Project Option: 1.6.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.
Performing Provider: University Medical Center - 137999206

Unique Project ID: 137999206.1.2
Project Components: 1.6.2.a-c

Project Description: Develop a call center utilizing nurses to help Medicaid and non-funded patients, who are seeking medical care services, the nurses utilize physician developed protocols to aid in the decision process to decide on the best care delivery system to use based on the expressed problems.

The project would improve access to sound medical guidance for Medicaid and non-funded patients seeking medical care. Effective telephone triage promotes the triple aim goals by providing timely access to medical setting guidance facilitating the directing of patients to the right care setting based on the symptoms described. It can aid in reducing costs by steering patients to the right level of care rather than directly to the emergency center. The call center can promote higher satisfaction in the patient population by reducing costs and wait times associated with care. In short, some primary care services and many healthcare tasks can be performed more quickly and inexpensively by phone than in person.

The population for this project is the semi urgent and non-urgent Medicaid and non-funded patients utilizing the University Medical Center emergency center. This population represents those that have the opportunity to choose a setting for care other than the emergency room. The intent of this project is to make urgent medical advice available to this population to assist them in identifying the most convenient, efficient and cost-effective setting to meet their specific health care need.

- **Goal:** The project Goal is to provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the Emergency Center (EC) can be reduced. The advice line provides callers with direct access to a registered nurse who can address their specific health needs with an on-demand service guided by physician developed and approved protocols.

  The five year goals would include:

  - the development of the system
  - addition of the appropriate staff
  - implementation of a training and quality assurance process to insure that staff have the knowledge and tools to provide sound advice
  - marketing of the call center to increase utilization by patients throughout the area served
  - decrease inappropriate utilization of the emergency center by non-urgent patients

- **Relationship to Regional Goals:** The regions primary goals are to be responsive to the issues identified in the community needs assessment. As the most critical need identified in the assessment, the severe shortage of primary care available in the region results in natural steerage of patients into the emergency rooms throughout the region. This call center project responds to the community need identification numbers CN.1 and CN.2. It will aid in getting patients medical care delivered timely, cost effectively and in the right setting. It will also aid in helping those patients that would typically come to the emergency room with behavioral health issues steered to the right behavioral health setting for their care.

- **Challenges:** The primary challenge associated with the implementation of an urgent medical advice line is gaining acceptance by the patient population. Many patients have come to rely on the emergency center to provide primary care services. One of the anticipated outcomes of this project is to help patient better understand the best location to receive those services. One of the best opportunities to change this is to actively market the urgent medical advice line to patients that are already utilizing the emergency center. Beyond direct communication to patients in the emergency center, marketing to the county population should further aid in overcoming this challenge.

Starting Point/Baseline: Currently, an Urgent Medical Advice line does not exist at University Medical Center. Therefore the baseline for the number of participants is 0.

A call center does not currently exist in the Lubbock are so we believe it will qualify as a significant new care delivery enhancement to the community. The rural area survey reflects 19% of our population finding it difficult to obtain medical care. The call center can help obtain an appointment, decrease language barriers, and decrease long waits in the Emergency center.

Rationale: A program is needed to provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the EC can be reduced. The advice line provides callers with direct access to a registered nurse who can address their specific health needs with an on-demand service.

The volume of semi urgent and non-urgent patients being triaged by the UMC EC in 2012 is 21,780 (28%). Of this 28%, The Medicaid CHIP, and non-funded represents 71% of those who have been triaged as semi-urgent and non-urgent This underscores their reality that they have nowhere else to go and decide to wait it out.

University Medical Center has the challenge of providing care to people with non-urgent conditions and who are seeking the EC for primary care. The decision to go to the EC is generally made by the medically underserved due to their limited financial resources. The situation, then, leads to people

leaving without being seen, long hours in the waiting room and overall dissatisfaction with the healthcare delivery system. The Rural Health Population (RHP) 12 needs assessment summary cites Lubbock County and especially the contiguous counties around Lubbock to be "Federally Designated Health Professional Shortage Areas" and too few of the providers that are in these counties accept Medicare, Medicaid or CHIP patients. University Medical Center's Emergency Center had over 72,000 visits during 2011 and is on track to exceed that in 2012.

The Call Center project addresses these two issues by directing these patients to providers that will accept their financial situation and provide the care needed in the time frame and setting that is appropriate to the expressed problem. The anticipated result is a decrease in non-urgent patients seeking care in the EC. In five years, the effect of the call system on the EC will result in less people leaving without being seen, less non-urgent patients waiting to be seen and less waiting room times for those who are there. Further, the medically underserved population will have an established relationship with a primary care delivery system. The call center specifically addresses the number one critical need in the region which is the need to improve access to primary care (CN.1). The call center does this by assisting patients that are unsure of the level of care they need by assessing their situation based on symptoms and steering them towards the optimal setting for delivering the care they need. There is currently no call center at UMC and no resource available for the patients in the population identified. It is a new initiative for the system.

The milestones and metrics selected in DY2 and DY3 including training nurses, educating patients and getting patients to use the system are all part of the foundation of a successful project. The DY4 and DY5 Milestones and metrics track our success with increasing the utilization of the call center by the population served. These measurements will help UMC implement the call center and impact the utilization of the emergency room thus reducing the burden of non-urgent and semi-urgent patients in the emergency room.

Core Project Components:

a) We will develop a process that in a timely manner triages patients seeking primary care services in an EC to an alternate primary care site. We will survey patients who use the nurse advice line to ensure patient satisfaction with the services received.

b) The system will assist to enhance linkages between primary care, urgent care, and the EC in order to increase communication and improve care transitions for patients.

c) We plan to conduct quality improvement for the call center. Activities may include, but are not limited to, identifying call center impacts on patient decisions, identifying "lessons learned" in directing patients over the phone, finding opportunities to scale all or part of the call center to a broader patient population, and identifying key challenges associated with expansion of the call center, including special considerations for underserved populations.

Relationship to other Performing Provider Projects: This project's focus on patient care in the appropriate settings ties to these Category 1 and 2 projects:

- 137999206.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
- 137999206.2.2 – Redesign Primary Care – SNF

The project is specifically designed to reduce the utilization of the emergency center for nor urgent and semi urgent care and to facilitate the identification of the right setting for specific health care needs. The call center will be a resource for both of the identified related project. Both populations in the identified projects are high utilizers of the emergency room. As such, having the resource of the call center available will help patients and their care givers make sound decisions about the urgency of their situation and the best setting for care.

Related Category 3 Outcome Measures:

Outcome Domain: OD-9 Right Care, Right Setting

IT-9.2. ED Appropriate Utilization

This outcome ideally tracks the success of the implementation of the call center. Because the main outcome goal for the project is the reduction in unnecessary utilization of the emergency center, tracking the change in volume of the non-urgent and semi-urgent patients will assess the effectiveness of the center.

Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Achieves Waiver Goals	The project Goal is to provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the Emergency Center (EC) can be reduced. The advice line provides callers with direct access to a registered nurse who can address their specific health needs with an on-demand service. The call center will be marketed to Medicaid patients as well as the un or underinsured patients of our community. These populations specifically need help in making decisions to access the most appropriate entry into the healthcare system. The volume of semi urgent and non-urgent patients being triaged by the UMC EC in in 2012 is 21,780(28%). The Medicaid CHIP, and non-funded patients represent 71% of those who have been triaged as semi-urgent and non-urgent. This underscores their reality that they have nowhere else to go and decide to wait it out in the EC.	5
Address Community Needs:	The RH12 Community Needs Identification #'s affected are CN.1; decreasing wait times in the EC and helping with access to care. CN.2; helping callers to obtain appointments. Our area survey reflects 19% of our population finds it difficult to obtain medical care. The call center can help obtain an appointment, decrease language barriers, and decrease long waits in the Emergency center.	5
Project Scope/Size:	The call center represents one of our larger projects in that a significant amount personnel, Office equipment and software programs will be required. When expanding this project to meet patient demand, it will require more nurses and more software licenses. Our initial outreach will be to patients who are discharged from the hospital, frequent users of the EC and our Medicaid program contacts. It is not clear in the literature how many EC visits will be avoided so it is difficult to project any savings. Some have experienced more volume in the EC since the call center allows you to see those who are now leaving without being seen because it helped to remove those in the waiting room who should not have been there anyway.	5
Project Investment:	The initial investment required of this project is projected at $241,000. Hire a Director and the initial 4.2 staff members for 24/7 coverage ($110,000), Set up an office with phone lines and equipment($6,000) and purchase/install software ($125,000)	5

137999206.1.2	***1.6.2***	***1.6.2.A-C***	***ESTABLISH/EXPAND ACCESS TO MEDICAL ADVICE AND DIRECTION TO THE APPROPRIATE LEVEL OF CARE TO REDUCE ED USE FOR NON-EMERGENT CONDITIONS AND INCREASE PATIENT ACCESS TO HEALTH CARE***	
University Medical Center				*137999206*
Related Category 3 Outcome Measure(s):	*137999206.3.2*	*IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-3 Train nurses on clinical protocols **Metric: P-3.1.** Number of nurses trained a. Numerator: number of nurses trained at baseline b. Denominator: total number of nurses **Baseline/Goal:** Train 5 people who will cover the nurse advise line 24/7 on the clinical protocols **Data Source:** HR records. **Milestone 1 Estimated Incentive Payment*:*** $1,213,996 **Milestone 2 -** P-6 Inform and educate patients on the nurse advice line **Metric: P-6.1** Number or percent of targeted patients informed/educated a. Numerator: Number of targeted patients informed/educated.		**Milestone 3**: **I-13** Increase in the number of patients that accessed the nurse advice line. **Metric 1 I-13.1** Utilization of Nurse Advice Line: a. Numerator: Number or percent of targeted patients that access the nurse advice line b. Denominator: Targeted patients **Baseline/Goal:** Baseline is zero. Our goal is to have 10% or 1,550 of the targeted population access the advice line. **Data Source:** Call Center Records **Milestone 3 Estimated**	**Milestone 4: I-13** Increase in the number of patients that accessed the nurse advice line. **Metric 1 I-13.1** Utilization of Nurse Advice Line a. Numerator: Number or percent of targeted patients that access the nurse advice line b. Denominator: Targeted patients **Baseline/Goal:** Baseline is zero. Our goal is to have 20% or 3,100 of the targeted population access the advice line. **Data Source:** Call Center Records **Milestone 4 Estimated**	**Milestone 5: I-13** Increase in the number of patients that accessed the nurse advice line. **Metric 1 I-13.1** Utilization of Nurse Advice Line a. Numerator: Number or percent of targeted patients that access the nurse advice line b. Denominator: Targeted patients **Baseline/Goal:** Baseline is zero. Our goal is to have 25% or 3,500 of the targeted population access the advice line. **Data Source:** Call Center Records Milestone 5 Estimated Incentive Payment: $ 2,194,508

137999206.1.2	***1.6.2***	***1.6.2.A-C***	***ESTABLISH/EXPAND ACCESS TO MEDICAL ADVICE AND DIRECTION TO THE APPROPRIATE LEVEL OF CARE TO REDUCE ED USE FOR NON-EMERGENT CONDITIONS AND INCREASE PATIENT ACCESS TO HEALTH CARE***	
University Medical Center				*137999206*
Related Category 3 Outcome Measure(s):	*137999206.3.2*	*IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
b. Denominator: Number of targeted patients (targeted as defined by UMC) **Baseline/Goal:** Provide the nurse line phone number/education to 25% or 3,500 of the Medicaid and non-funded patients via US Mail. **Data Source**EMR note or mail sent **Milestone 2 Estimated Incentive Payment *:*** 1,213,997		**Incentive Payment:** $2,648,810	**Incentive Payment:** $2,656,510	
Year 2 Estimated Milestone Bundle Amount*:* $ 2,427,993	Year 3 Estimated Milestone Bundle Amount: $ 2,648,810		Year 4 Estimated Milestone Bundle Amount: $ 2,656,510	Year 5 Estimated Milestone Bundle Amount: $ 2,194,508
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $9,927,821				

Project Option: 1.10.1 Enhance improvement capacity within people
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.1.3

Project Description:
University Medical Center (UMC) will adopt a performance improvement methodology such as LEAN / Six Sigma.

- **Provider:** University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.
- **Interventions(s):** This project will be to select a method for performance improvement such as LEAN/Six Sigma, based on evidence based data and multi-facility references. UMC will implement a train-the-trainer methodology for a quick and efficient process to roll the methodology out to those involved in performance improvement and will then implement the methodology within a trial area. The results of the trial will be reviewed and adjustments will be made in the methodology and approach to maximize the efficacy of the project. Once that is completed, the project will be rolled out house-wide and performance improvement projects will be performed utilizing the methodology. An employee suggestions process will be adopted to provide continuous feedback on the effectiveness of the process.
- **Need for the project:** While quality is everyone's job, it essentially remains the purview of a few performance improvement leaders within UMC. To truly impact quality and patient safety, the role of performance improvement needs to be extended to all leaders and staff to ensure that metrics like never events, HAIs and HACs approach zero and core measures are at their highest level of compliance. Acclamation to change remains slow and the required timeframe for improvement requires much quicker adoption of change and a drive towards rapid improvement.
- **Target population:** The target population will be all inpatients treated at UMC including non-funded, Medicaid and those with other funding sources. Over 20% of the patients treated at UMC are on Medicaid and another 15% of the total patients having no source for funding. This project at a minimum will address the Emergency Center and Surgery, affecting 93,000 patients in 2012.
- **Category 1 or 2 expected patient benefits:** This project seeks to improve inpatient outcomes through employee engagement, derived through training and supported by a very strong culture of service. The outcome should be reductions in complications and healthcare acquired conditions.
    - DY3: Provide training to at least 650 staff members
    - DY4: Utilizing Lean/Six Sigma methodology, drive 5 rapid-cycle performance improvement projects of which the Emergency Center and Surgery are a primary focus. In doing so will decrease length of stay, readmission, mortality, added costs, weight times as well as time to be seen and increased patient satisfaction
    - DY5: Continued focus on the 5 rapid-cycle performance improvement projects of which the Emergency Center and Surgery continue to be a primary focus.

- **Category 3 outcomes:** IT-4.4 Surgical Site Infections. Our goal is to reduce surgical site infection rates at UMC.

Project Option: 1.10.1 Enhance improvement capacity within people
Performing Provider: University Medical Center - 137999206
Unique Identification Number: 137999206.1.3
Project Components: 1.10.1.a, b

- **Project Description:** Over the last two decades, the function of Performance Improvement has evolved from quality control to quality improvement, and now to performance improvement. The Joint Commission requires each hospital to establish a process, a method to ensure performance improvement occurs. However, they do not require the level of enhancement described herein. A standard approach for "making improvement happen" is essential, to ensure that measurement is meaningful, stakeholders are involved, and results are sustainable. As performance improvement in healthcare has evolved, non-healthcare sophistication by way of quality methodologies, have become well known and proven. Examples include LEAN and Six Sigma. Health care organizations, particularly “assembly line” operations such as clinical labs, have embraced them in order to compete with a rapidly changing market. This project is about adoption: UMC will adopt a performance improvement methodology such as LEAN / Six Sigma. The purpose is far reaching: To facilitate a culture of continual improvement, and "rapid cycle improvement" as led by trained experts.

  The process of implementation will be as follows:
  - Select a method based on evidence based data and multi-facility references; involve stakeholders in the selection process
  - Train the trainer – select a multi-disciplinary group of trainers; ensure they receive adequate training modules
  - Implement tools within a trial area (example: Med Surg Units)
  - Check results – i.e., assess the utilization of the methodology in problem solving
  - Re-assess before housewide rollout
  - Housewide implementation

  In addition to training and education on performance improvement strategies, an employee suggestion system will be developed, designed to identify issues or concerns that impact the work environment, patient care and satisfaction, efficiency and related concepts within the realm of performance improvement. UMC has had limited success with employee suggestion models; this must be a new system that engages employees’ interest, perhaps with incentives toward implementation. A primary challenge will be determining the capacity of each suggestion to render a measured improvement. Thus, this system will rely on the employee submitter to accomplish upfront research toward an initial return on investment. Fortunately UMC has a strong culture of employee satisfaction; therefore a new system will be built with the participation of the employee base.

- Our population will be all inpatients treated at UMC including funded, non-funded and under-funded patients. This project at a minimum will address the Emergency Center and Surgery, affecting 93,000 patients in 2012.

- **Project Goals:** Our goal is improved inpatient outcomes through employee engagement, derived through training and supported by a very strong culture of service. This goal will manifest itself through reduction in complications and healthcare acquired conditions (moving the dial). Following in the path of similar cultural initiatives at UMC (service, safety), this "movement" will empower staff with tools to improve our systems, processes, and outcomes.
    - The goal is to have 125 leaders trained in the methodology of choice who then will provide education to 500 staff, for a total of 650 employees participating in at least 5 events during DY3.
    - Demonstrate how quality reports are used to drive rapid-cycle performance improvement through implementation of five performance activities utilizing Lean/Six Sigma methodology as a result of information provided on the reports. Two primary areas of focus include the Emergency Center and Surgery during DY4 & DY5 in order to decrease length of stay, readmission, mortality, added costs and weight times as well as time to be seen and increased patient satisfaction.
    - Reduce complications
    - Reduce healthcare acquired conditions
- **Challenges:** As with any professional training, the primary challenge will be to ensure the methodology seen in training is lived out on the patient floor. Empowering and incentivizing front line nursing staff to “champion” a project or initiative and thereby requiring them to utilize the tools of the methodology, will go a long way in grounding this process in spite of staff turnover.
- **5-Year Outcome:** At least 12 months with ZERO hospital acquired conditions (= lower ALOS and lower cost).
- **Relationship to Regional Goals: :** The regions primary goals are to be responsive to the issues identified in the community needs assessment and to achieve progress towards the triple aim goals of improving the patient experience including quality and satisfaction, improving the health of populations and reducing the per capita cost of care. This project will contribute towards improving the quality and satisfaction of the patient and reduce the associated cost of providing care by providing implementing evidenced based process improvement strategies to reduce healthcare acquired conditions. Additionally, the project will accelerate the process associated with identifying and correcting issues that impact the quality and safety of care delivered. This project directly impacts CN.1 as it relates to cost of care, CN.3 and care of the unfunded, and CN.5 and care for those with chronic conditions.
- **Starting Point/Baseline:** Currently, the number of staff trained as experts in a recognized P.I. methodology: < 10
- **Rationale:** "Quality is everyone's job." That has been said for a long while, but it remains essentially, the purview of a few P.I. leaders within UMC. It must be extended to all leaders, all staff, to ensure that metrics like never events, HAIs and HACs, approach zero, and core measures for instance, are at the highest level of compliance. Additional Rationale: UMC has successfully embraced a culture of service - with hardwired metrics, resulting in top tier performance for patient experience. This same type of roll-out will

occur re: quality, given the best-suited methodology as a foundation. If we do not employ this project, the acclamation to change will be slower, as will the required timeframe for improvement. According to AHRQ, evidence-based methodologies are most successful when backed by strong leadership commitment and culture of quality/safety. These are/will be present, to ensure success for this project.

This project addresses community needs including CN.4 and CN.5 by driving improvement in processes and procedures that will have a direct impact on the care provided to patients with chronic conditions and other healthcare issues. UMC is a Level 1 trauma center and has the only burn center for hundreds of miles. As mentioned in the needs assessment and identified in CN.3 and CN.1, we have a high level of unfunded patients and a lack of adequate access to care for the surrounding region. Through improvements in process and efficiency within the system, UMC can provide higher quality and cost effective care for the underserved population in our region.

The required components for this project are a) provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture and b) Develop an employee suggestions system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. These components were selected because they provided the highest level of opportunity for UMC to make meaningful change in its approach to drive improvements throughout the system. While UMC has had success with improvements in the past, UMC has lacked a structure and process that would allow for accountable, efficient improvement to address key issues. Additionally, our employees are goal aligned as demonstrated in high employee satisfaction scores and they are UMC's greatest asset. By formalizing a process to allow employees to provide feedback on issues, we believe that UMC can continue to drive patient safety, quality and outcomes. Milestone P-2 establishes the program described above, a train-the-trainer approach toward hospital wide knowledge and engagement. Other venues for knowledge building are described in Milestone P-4.Even with adequate training, it will be essential for the performance improvement process to a) produce meaningful reports of progress and b) hasten the cycle of improvement, as described in Metrics I-7.1 and I-7.2. The volume of new performance measures hitting the hospital via healthcare reform, as well as the speed with which they come, will make these metrics absolutely necessary. While UMC has been focused on performance improvement, this project is a new initiative in that it will provide training and education for those within the facility that will implement strategies for formalized and proven improvement strategies.

- **Related Category 3 Outcome Measure(s):**
  Outcome Domain: OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions
  IT-4.4. Surgical Site Infections (SSI) rates
  Surgical site infections cost lives, extended hospital stays, and dollars for the payers. This Category 3 measure crosses boundaries, from pre-operative to the OR suite to post-operative care, from housekeeping to sterile supply. To drive SSI rates to zero, it will

require front line staff to fully understand and engage in the actions of performance improvement. Thus, a method as described in the related category 1 project will provide the foundation for significant improvement.

- **Relationship to other Projects:** This project relates to 137999206.2.1 Expand chronic care management models and 137999206.2.3 Conduct Medication Management. Both of these related projects will benefit from the more efficient and effective method of applying performance improvement strategies to the process of delivering care to patients.
- **Relationship to Other Performing Providers' Projects in the RHP:** N/A
- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to-face meetings, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Within an organization of 3000+ employees and 400+ professional staff, the ability to "move the dial" and to improve outcomes stems in large part from an awareness/education of the process…how do you improve from point A to point B. To achieve waiver goals, and to achieve them in a timely fashion, requires adoption of a evidence based methodology or system. Beyond tracking national metrics like core measures, the Triple Aim goals are dependent upon a culture of improvement that is known, understood and available to the front line staff. That is what a P.I. program/system can do. This foundational building block will positively influence every other hospital-based project considered. The literature from AHRQ, NQF and a wide array of hospitals, lab departments, etc. indicates a considerable return on investment.	**5**
Addresses Community Need(s)	If we are to address readmissions, hospital acquired infections, etc. toward the benefit of our community, this project addresses those needs. The needs will always outweigh resources. This project helps the hospital use its limited resources more efficiently and effectively.	**4**
Project Scope/Size	If one values the importance of an organizational culture that educates and empowers staff to "make improvements happen" then this is a large project. It affects current as well as future results. It applies to any and all patients as well as any and all staff.	**5**

Project Investment	Investment will be in curriculum and training expense, but far and above the primary investment will be in time – for training but more so for implementation day to day.	**3**

137999206.1.3	1.10.1	*1.10.1.a,b*	Enhance improvement capacity within people
University Medical Center		**137999206**	
Related Category 3 Outcome Measure(s):	**137999206.3.3**	**IT-4.4**	**Surgical Site Infections (SSI) rates**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-2 Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in the program should be required to lead an improvement project in their dept. within 6 months of completed training. **Metric: P-2.1** Train the trainer program established **Baseline/Goal:** There is currently no train-the-trainer program. The goal is to develop the program and prepare it for roll-out to staff. **Numerator:** # of staff trained through the train the trainer prog. **Data Source:** Training material/logs **Metric: P-2.2** Improvement projects led by staff trained through the train the trainer program. **Baseline/Goal:** There is currently no program in place to do this so the baseline is zero. The goal is to have five projects within six months that will utilize this model. **Numerator:** # of improvement projects led by staff trained	**Process Milestone P-4:** Participate in/present to quality/performance improvement conferences, webinars, learning sessions or other venues **Metric: P-4.1:** Number of learning events attended and number of learning events at which a presentation was delivered summarizing the provider's improvement activities and results **Baseline/Goal:** There is currently no effort in place to attend learning events on this topic. . The goal is to have 125 leaders trained in the methodology of choice who will then provide education to 500 staff, for a total of 650 employees participating in at least 5 events during the year. **Data Source:** Agenda and abstracts. **Estimated Milestone 2 Incentive Payment:** **$2,369,988**	**Improvement Milestone I-7:** Implement quality improvement data systems, collection, and reporting Capabilities **Metric: I-7.1:** Increase the number of reports generated through these quality improvement data systems Numerator: Number of reports generated. **Baseline/Goal:** There are currently no reports generated that would be addressed under this model. The goal is to increase the reports generated that will be incorporated in this model by at least 10 reports **Data Source:** Quality improvement data systems. **Metric: I-7.2:** Demonstrate how quality reports are used to drive rapid-cycle performance improvement. **Baseline/Goal:** There are currently no performance activities that utilize the reporting and process from this model. The goal is to implement five performance activities utilizing Lean/Six Sigma methodology as a result of information provided on the	**Improvement Milestone I-7:** Implement quality improvement data systems, collection, and reporting Capabilities **Metric: I-7.2:** Demonstrate how quality reports are used to drive rapid-cycle performance improvement. Baseline/Goal: There are currently no performance activities that utilize the reporting and process from this model. The goal is to continue with the implementation of the five performance activities utilizing Lean/Six Sigma methodology as a result of information provided on the reports, including the Emergency Center and Surgery (affecting 93,000 patients). Numerator: Number of performance activities that were designed and implemented based on the data in the reports. **Data Source:** Documentation from quality improvement office. **Estimated Milestone 4 Incentive Payment:** **$1,963,507**

through the program within 6 months of completed training. **Data Source:** Documentation of improvement projects. **Estimated Milestone 1 Incentive Payment:** **$2,172,414**		reports. Two primary areas of focus include the Emergency Center and Surgery affecting 93,000 patients annually overall. Numerator: Number of performance activities that were designed and implemented based on the data in the reports. **Data Source:** Documentation from quality improvement office. **Estimated Milestone 3 Incentive Payment:** **$2,376,877**	
DY 2 Estimated Milestone Bundle Amount: $2,172,414	DY 3 Estimated Milestone Bundle Amount: $2,369,988	DY4 Estimated Milestone Bundle Amount: $2,376,877	*DY5 Estimated Milestone Bundle Amount: $1,963,507*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):$8,882,786			

Project Option: 1.11.3: Other project option
Performing Provider: West Texas Centers/130725806
Unique Identification Number: 130725806.1.1

Provider: West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health and intellectual and developmental disabilities for the established service area. The Center serves as the designated local authority for mental health through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in eight counties in the RHP 12 area. West Texas Centers operates six mental health clinics in six of these eight extremely rural counties and employees approximately 22.5 full time equivalent (FTE) staff serving an average of 445 persons per month. These clinics are full time service sites, offering a wide array of mental health services (many done through telemedicine) to include 24 hour crisis intervention, case management, psychiatric evaluation and consultation, medication management, supported housing and employment and psychiatric rehabilitation. We are the only behavioral health care provider in most if not all of the counties we serve in RHP 12.
Intervention: This project will enable WTC to purchase and install additional equipment to increase the capacity of our current telemedicine network. Additional broadband, hardware and software will provide additional hours of provider time to consumers in these counties/clinics. WTC will increase its telemedicine service capacity by purchasing and installing additional equipment, software and bandwidth in six of the 8 very rural counties in RHP 12 where WTC operates mental health clinics serving over 700 patients annually. Equipment increases will provide additional hours of provider time to WTC consumers in RHP 12 counties. Additional provider availability will be established once the hardware infrastructure to expand the telemedicine network has been completed. This will increase physician availability across the very rural area, decreasing appointment wait times and inappropriate law enforcement incarcerations and emergency room admissions. This project will be an expansion of West Texas Centers' current telemedicine network.
Need for the Project: Current wait times for appointments in these areas are over thirty days, with physician clinics scheduled weekly or even less often due to the lack of telemedicine infrastructure. Current crisis services are averaging over 500 calls per month to WTC for residents in these counties, with over five hundred of those calls "go mobile" calls. Delays in obtaining psychiatric appointments often result in consumers experiencing preventable crisis situations, which frequently require costly hospitalizations. This very rural area does not offer sufficient quality of life opportunities to attract "on site" providers. Telemedicine is the only mechanism available in most cases to provide behavioral health care to this large geographic area where there is little to no public transportation and all healthcare services are extremely limited. Once the network expansion has occurred additional physician and nursing hours can be procured which will increase available appointments and decrease consumer wait times.
Target Population: West Texas Center's patient population is 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years and it is estimated this percentage will be similar throughout the project.
Category 1 patient benefits: I In DY 3 WTC will increase psychiatrist time through recruitment by .20 FTE. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 2443 with an additional annual increase to 2536 in DY

5. Even though every new appointment slot represents a person, it is impossible to estimate the number of *new* patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.
Category 3 outcomes: West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems being selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.

Project Option: 1.11.3: Other project option.
Performing Provider: West Texas Centers/130725806
Unique Identification Number: 130725806.1.1
Project Title: West Texas Center RHP 12 Telemedicine Expansion
Project Description: West Texas Centers will expand access to behavioral health care through expansion of our current telemedicine network in Dawson, Gaines, Garza, Scurry, Terry and Yoakum Counties. All West Texas Center Counties in the RHP are served primarily via a current telemedicine system from the hub site of Big Spring, Texas. Acquisition of additional broadband capacity, hardware, software, office space, support staff and expansion of existing professional personnel contracts will provide increased access to care for consumers. According to the Health Resources and Services Administration (HRSA) as presented through the Department of State Health Services, all West Texas Center counties in RHP 12 meet the federally designated status of mental health professional shortage areas. http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm. Given this data, it is evident that all the West Texas Center counties have very limited to almost no access to local psychiatric service providers for the behavioral health population other than West Texas Centers. This creates increased hardship for individuals and families who have limited or no funds to travel to areas with psychiatric availability. Despite the limited access to care, consumer need has not been diminished and is often provided by non-mental health agencies. West Texas Centers sends consumers to inpatient facilities located forty-five to one hundred miles from any of the WTC counties in the RHP. Additionally, counties and law enforcement must often send individuals with psychiatric needs to local emergency departments in their own county, and adjoining county or to a distant urban location. This has significant costs to all counties through potentially unnecessary use of law enforcement personnel, where resources are already stretched, avoidable incarcerations, ambulance services, and emergency department use. Due to the difficult nature of obtaining and keeping psychiatric services in rural areas it is necessary to develop and implement other strategies to provide the needed services for the behavioral health population. West Texas Center's current telemedicine capacity is essential to the provision of psychiatric services, but cannot meet the growing needs associated with fewer options for transportation and the extreme difficulty of provider recruitment. With the Center serving over 500 crisis situations during FY 2012 non inclusive of non urgent patient needs, the current telemedicine infrastructure is simply not enough to meet the growing need. This project will increase the Centers capacity by adding psychiatrist appointment slots to all WTC RHP 12 mental health clinics as well as support other projects within the region such as an integration of primary and behavioral health occurring in Dawson County and a Pass 2 project expanding WTC's Mobile Crisis Outreach Team. Each contact made through telemedicine is tracked through our internal computer program, Anasazi. Our goal, at the end of the project, is a reduction in the number of behavioral health clients seeking both crisis and routine behavioral health services through emergency departments, reducing the amount of hospitalizations for behavioral health crises and expanding access to behavioral health care services in the counties we serve. Six of the existing mental health clinics West Texas Centers operates in these locations will have increased access to psychiatric appointments as a result of this project. The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). The services provided by the mental health authority are specific to DSHS's Texas Recovery and

Resiliency model of care. We do not believe the project duplicates another provider's intervention for the same target population. West Texas Center's currently serves a patient population of 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years and will be the target population for the project.

Project Goals: Goals will include reduced patient wait times, and decreased times for emergency departments and law enforcement personnel to be involved in crisis response activities. In DY 3 WTC will increase psychiatrist time through recruitment by .20 FTE. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 2443 with an additional annual increase to 2536 in DY 5. Even though every new appointment slot represents a person, it is impossible to estimate the number of *new* patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

Project Challenges: Challenges will include continued difficulty in recruitment of professionals and paraprofessionals to this very rural area. To meet this challenge expansion of current West Texas Center's professional contracts will enable faster project development during DY 3, while ongoing employment type recruitment activities continue through DY 4 and 5. An additional challenge will include procurement times associated with broadband expansion, as providers of these services are currently close to capacity due to the exceptionally robust economy in the West Texas area.

Five Year Expected Outcome: . It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 2443 with an additional annual increase to 2536 in DY 5. Even though every new appointment slot represents a person, it is impossible to estimate the number of *new* patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

Relationship to Regional Goals: This project will work to transform health care delivery from a disease focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of the existing behavioral health care system; and infrastructure, is responsive to patient needs throughout the region and improves health care outcomes and patient satisfaction.

Starting Point/Baseline: Baseline encounter data will be obtained from WTC fiscal year 2012 records as well as other data relevant to this project. Data sources will include the Avail Solutions Crisis Hotline data, Anasazi data which is the Centers current behavioral health software provider and Department of State Health Services Encounter data. WTC will continue to identify and refine baseline data with the final baseline being established no later than the end of DY 2.

Rationale: West Texas Centers currently operates telemedicine in the project counties. West Texas Centers primarily serves a population eligible for services only if 200% or less below the Federal Poverty Guidelines; otherwise they are eligible as private pay only. The patient population expected to be served by this project is on average 45% Medicaid and 54% indigent or persons with no pay source. With this population coupled with a very rural, remote geography this project will target those persons least able to access care in the area. FY 2012 the WTC Counties in RHP 12 experienced over 350 "go mobile" crisis calls and maintains a current caseload of over 750. Staff turnover, recruitment challenges, travel requirements, and training needs continue to increase. Ongoing assessment of our current telemedicine network is necessary to insure the most up to date and cost effective technology, equipment and processes are in place. Additional

broadband and equipment will provide the necessary infrastructure to recruit and train "distance" providers, who are in many cases, the only provider available for both non urgent and crisis services. This expansion of telemedicine will increase diversions from emergency rooms and law enforcement incarceration while providing faster more real time assistance to the consumer in crisis. In the non urgent situation, this expansion will provide additional physician clinic days where currently capacity is at maximum with the waiting time for appointments averaging 14 to 18 days and often over thirty. Existing technical infrastructure at these locations is inadequate to provide additional needed access to psychiatric assessment and medication management capacity. g. It was not possible to utilize project option 1.11.1 or 1.11.2 for this project as this is not an implementation of telemedicine but an expansion of our current telemedicine network. In order however to stay as close to the Category 1 protocol document as possible the decision made to select "other" project option of 1.11.3(Cat 1, pg127). Those core components which would apply to an expansion of telemedicine were selected from 1.11.1 and l.11.2 project options (Cat 1 pg 126) and are as follows:

Option a) 1.11.2 pg 126: development or adapt current administrative and clinical protocols that will serve as a manual of technology-assisted operations;engage in rapid cycle improvement to evaluate the processes and procedures in the expanded telemedicine project and make any necessary modifications;

c) 1.11.2 pg 126: identify and train qualified behavioral health providers and peers that will connect to provide expanded telemedicine, to primary care providers, specialty health providers, peers or behavioral health providers. Connections could be provider to provider, provider to patient or peer to peer;

d) 1.11.2 pg 127: identify modifiers needed to track encounters performed via expanded telehealth technology;

e) 1.11.2 pg 127: develop and implement data collection and reporting standards for expanded electronically delivered services; and

h) 1.11.2 pg 127: assess impact on patient experience outcomes (e.g. preventable in inpatient readmissions).

West Texas Centers will recruit and train additional personnel to perform enhanced quality improvement activities to develop administrative protocols related to its telemedicine services. WTC will also utilize current administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring. Additionally WTC will enhance its current data collection systems to capture data specifically related to this project to include more specific data around patient outcomes resulting from services received through telemedicine. West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project.

Milestones and Metrics:

This project is an expansion of *existing* telemedicine infrastructure so in order to stay as close to the Category 1 protocol document as possible Project Option of 1.11.3(Cat1, pg 127): Other was selected however; process milestones for this project were customized from Project options 1.11.1 and 1.11.2 (Cat 1 page 126-127) and identified as customized in the milestone/metric table. Process milestones were selected to immediately begin assessment of the current systems and begin analysis of the best value, most cost effective decisions regarding equipment, broadband and technology upgrades and procurement. DY 2 Milestones 1: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment and Milestone 2: Procurement of additional Broadband Connection, were selected to begin

the process of upgrade and expansion of WTC's current telemedicine network. DY 3 Milestone 3: Hire tele-presenters, as needed, for remote site equipment expansion operation and Milestone 4: Training for providers/peers on use of equipment/software will provide the staffing and training necessary for the expanded telemed capacity to be in place by end of DY 3 achieving an increase in psychiatrist time through recruitment by .20 FTE .

Improvement milestones for DY 4 and 5 were selected and customized using language from the protocol wherever possible. Improvement milestones were selected based upon information identified both in the RHP needs assessment sections CAN 3 and WTCS own needs assessment process.

The customized Improvement Milestone 5: I-X-1 in DY 4 and again Milestone 6: I-X-2 in DY 5: "Increase access to behavioral health care" was used. Metrics for this milestone were customized for behavioral health care from language in Cat 1 Improvement Target I-15.2 pg 22): "Increase number of primary care visits"(changed in this project to: "increase number of behavioral health care visits"). It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 2443 with an additional annual increase to 2536 in DY 5. Even though every new appointment slot represents a person, it is impossible to estimate the number of *new* patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

Continuous Quality Improvement: West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution. The associated category 3 outcome measures related to patient satisfaction and the corresponding survey instruments will also be used in establishing continuous quality improvement protocols.

Community Needs Identification Number the Project addresses: RHP 12 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lock of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP.

New or Enhanced Initiative: This project is an enhancement to the current telemedicine network West Texas Centers currently operates in these counties. This is significant in that start up costs and time associated with an initial project of telemedicine installation is extremely significant. This project will have the primary structure and process in place to rapidly develop the enhanced technology components and decrease the amount of time necessary to begin actual service delivery utilizing the new systems.

Related Category 3 Outcome Measure(s): West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems being selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was

selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. **Relationship to other Projects:** West Texas Centers is also proposing Project Number 130725806.1.2expansion of WTC mobile crisis outreach staff and a RHP 12 Dawson County behavioral health and primary care integration project number 130725806.2.1.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Project will decrease cost of care through economies of scale related to psychiatrist travel cost per visit and limited availability. Will reduce or eliminate in some cases no-show appointments. West Texas Centers serves primarily Medicaid and uninsured consumers thus reaching a high risk, high need population. This project will lessen the wait time for consumers to see a physician and will significantly increase access in extremely rural areas. Consideration was given to current crisis response times in the project Counties, county patient satisfaction with current telemedicine technology/services, availability of other behavioral health providers and length of waiting time for psychiatric services in the project locations. RHP 12 goals include seeking to transform health care by bending the cost curve. This project should support this goal in that it will increase WTC capacity to provide diversionary services for clients from higher cost forms of treatment such as hospitals and jails. The regional goals also include transforming health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time treatment. This project will accomplish those goals through increased access to care in very rural areas, where resources such as transportation and physician time are extremely scarce.	**5**
Addresses Community Need(s)	Currently counties served by this project have limited access to psychiatrist time through the current telemedicine system. This project will increase that time to add approximately ten hours per week aggregate to physician coverage in these counties. These counties area gradually losing population due to their rural nature and the cost associated with living in the rural area, therefore this project will meet the community needs as described in the assessment; however it is anticipated as the population decreases the need for behavioral health services typically increases. This project relates to RHP 12 goals of improving overall healthcare access in the region by expanding access to behavioral health care services	**3**
Project Scope/Size	By DY 3 WTC will increase psychiatrist time through recruitment by .20 FTE. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 2443 with an additional annual increase to 2536 in DY 5. Even though every new appointment slot represents a person, it is impossible to estimate the number of *new* patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.	**3**
Project Investment	Project will require significant purchase of costly equipment, relatively short implementation timeframes and minimum risk. Improvement milestones should be achieved within established schedules. West Texas Centers other project in the region is a primary and behavioral health care integration with significantly higher risk, costs and human resource requirements than this project.	**2**

130725806.1.1	1.11.3 OTHER	1.11.2 A-H	In an innovative manner not described above, implement other evidence-based, technology-assisted services to support, coordinate, or deliver behavioral health services.
West Texas Centers			130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction IT-6.2: Other Outcome Improvement Target TBD	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-X-1(customized milestone and metric with language used from Cat 1 P-4-1; pg 128) Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment. P-X.1 Metric: Inventory of new equipment purchased Data Source: Review of inventory or receipts for purchase of equipment. Baseline: 2012 Inventory of WTC telemedicine equipment. Goal: Purchase all necessary equipment for the project Milestone 1 Estimated Incentive Payment $150,917.00 Milestone 2 P-X-2(customized milestone and metric with language used from Cat 1 P-5; pg 128) Procurement of additional Broadband	Milestone 3 P-X-3 (customized from milestone and metric with language used from Cat 1, P-7; pg 128) Hire tele-presenters, as needed, for remote site equipment expansion operation. P-X-3 Metric: Documentation of acquisition of proper staff/training to operate expanded equipment capacity at Provider locations. Data Source: Interviews with staff, review of hiring or payroll records, contracts Baseline: FY 2012 psychiatrist FTE count Goal: Will increase psychiatrist by .20 FTE Milestone 3 Estimated Incentive Payment: $156,294.00 Milestone 4 P-X-4 (customized milestone and metric with language used from Cat 1, P-8, pg 128) Training for providers/peers on use of	Improvement Milestone 5 I-X-1(customized measure and metric language used from Cat 1 Improvement Target I-15.2 pg 22) Increase access to behavioral health care capacity I-X-5 Metric: Increase number of behavioral health care visits. a. Total number of visits for reporting period. b. Data Source: West Texas Centers FY 2012 claims, encounter and other internal data sources. Baseline: WTC total 2012 telemed appointment slots for these project locations. Goal: Will increase the total number of telemedicine appointment slots/persons seen from DY 2 baseline to an annual total of 2443 in DY 4.	Milestone 6 I-X-2 (customized measure and metric from Cat 1 Improvement Target I-15.2 pg 22) Increase access to behavioral health care capacity I-X-5 Metric: Increase number of behavioral health care visits. a. Total number of visits for reporting period. b. Data Source: West Texas Centers FY 2012 claims, encounter and other internal data sources. Baseline: WTC total 2012 telemed appointment slots for these project locations. Goal: Will increase the total number of telemedicine appointment slots/persons seen from DY 2 baseline to an annual total of 2536 in DY 4.

130725806.1.1	1.11.3 OTHER	1.11.2 A-H	In an innovative manner not described above, implement other evidence-based, technology-assisted services to support, coordinate, or deliver behavioral health services.
West Texas Centers			130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction IT-6.2: Other Outcome Improvement Target TBD	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Connection P-X-2 Metric: Documentation of presence of active broadband connections Data Source: Review of purchase receipt or demonstration of equipment Baseline: FY 2012 WTC Broadband invoice data Goal: Procure and implement expansion of all Broadband connections required for project. Milestone 2 Estimated Incentive Payment $150,917.00	equipment/software P-X-4 Metric: Documentation of completions of training on use of equipment/software Data Source: Training roster Baseline: FY 2012 WTC Provider training records Goal: Complete training on use of equipment/software for all providers utilizing telemedicine in the project. Milestone 4 Estimated Incentive Payment: $156,294.00	Milestone 5 Estimated Incentive Payment: $334,417.00	Milestone 6 Estimated Incentive Payment: $323,057
Year 2 Estimated Milestone Bundle Amount: $301,834	Year 3 Estimated Milestone Bundle Amount: $312,588	Year 4 Estimated Milestone Bundle Amount: $334,417	Year 5 Estimated Milestone Bundle Amount: $323,057
Total Estimated DSRIP Funding for 4 Years :$1,271,896			

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
RHP Performing Provider: West Texas Centers / 130725806
RHP Project Number: 130725806.1.2 – **"PASS 2"**
Project Components: 1.13.1.a-e

Provider: West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health for the established service area through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in eight counties in the RHP 12 area. West Texas Centers operates six mental health clinics in six of these eight extremely rural counties.
Intervention: West Texas Centers will expand its current Mobile Crisis Outreach Team staff by a minimum of one additional qualified mental health provider. These additional staffs will effectively double the current capacity of the Centers crisis response system in these counties. This project will enable WTC to improve our crisis response time providing intervention in the crisis event, in many cases avoiding an inappropriate hospital admission or incarceration. Increasing our ability to potentially intervene in a behavioral health crisis prior to the consumer being booked into the jail, admitted to the ED or taken to a psychiatric hospital for admission will have a significant impact on consumer quality of life, and quality of care as well as provide a much more cost effective treatment alternative. Follow up with patients who have experienced a mental health crisis event is a critical component in preventing repeat crisis situations. WTC currently has very limited resources to provide this follow up. This project will provide additional resources to increase and improve crisis support services related to prevention, wrap around, case management and other "support" type services necessary to maintain patient stabilization.
Need for the Project: Current crisis services are averaging over 500 calls per month to WTC for residents in these counties, with over five hundred of those calls "go mobile" calls. These calls are handled currently by only one clinical on call staff person. This project will effectively decrease wait times for crisis response in all 8 counties served by WTC within the RHP.
Target Population: This project is expected to serve roughly 45% Medicaid and 54% uninsured with the remaining percentage of patients having some form of third party insurance; however, because we are the public safety net for behavioral health, the target population for this project would include any person in the WTC service area experiencing a psychiatric emergency and accessing the WTC crisis hotline
Category 1 patient benefits: The overall project will increase access to behavioral health care crisis services in these locations by doubling the number of crisis response staff to address the crisis in the most appropriate setting and in the timeliest way possibleBy DY 3 the project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 266 diversions or 266 persons diverted annually. DY 4 the project will see 20% or 290 persons annually diverted and by DY 5 the

utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 326 diversions or 326 persons diverted annually.**Category 3 outcomes:** WTC has selected for demonstration years 3-5, Improvement Target IT-9.1(standalone measure): Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (standalone measure). Baseline for these targets will be related to diversion and incarceration data from WTC FY 2012, gap analysis data from DY 2 and information obtained from PDSA cycles in DY 3.

Improvement Targets for DY 4 and DY 5 will be:

- DY4-IT-9.1:Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population
- DY5-IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population.

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Project Title: West Texas Centers Mobile Crisis Outreach Team Expansion
RHP Performing Provider: West Texas Centers / 130725806
RHP Project Number: 130725806.1.2- **"Pass 2"**
Project Components: 1.13.1.a-e

Project Description: This project will expand the capacity of West Texas Centers behavioral health services to better meet the needs of the patient population and the community in order for care to be better coordinated and the patient being treated as a whole person potentially leading to better outcomes and experience of care. West Texas Centers will perform a gap analysis of it's current crisis response system for the counties the Center serves in the RHP 12. This analysis will identify barriers, potential cost savings, community needs and overall crisis response processes which may need refinement or expansion. Additionally community needs will be further met through public forums and stakeholder meetings to help identify specific West Texas Centers crisis response system needs. West Texas Centers will expand its current Mobile Crisis Outreach staff by a minimum of one additional qualified mental health provider. These additional staffs will effectively double the current capacity of the Centers crisis response system in these counties.
West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health and intellectual and developmental disabilities for the established service area. West Texas Centers provides mental health services in eight counties in the RHP 12 area. Helen Farabee Center is also a community center operating under the same provisions as West Texas Centers, but serving a completely different geographic area within RHP 12. There is no overlap of service areas between the two centers. Helen Farabee has proposed several 1115 Waiver projects, but was unable to utilize their full DSRIP allocation in Pass 2 for RHP 12. In order to assist further in transformational activities related to behavioral health they provided West Texas Centers with a portion of their unused DSRIP in the amount of $ 19,525. West Texas Centers has included this allocation with WTC's Pass 2 project allocation and will be providing the IGT required for the total of the two. WTC's Pass 2 Project: Mobile Crisis Outreach Expansion will decrease crisis wait times and result in more appropriate less costly solutions including diversion from emergency departments and law enforcement settings through the delivery of additional "wrap around", preventive and follow-up crisis services *for the WTC service area only.* West Texas Centers and Helen Farabee Center are both publically funded governmental entities. For this reason West Texas Centers does not believe the DSRIP funds provided to WTC by Helen Farabee meet the definition of a provider relation donation as defined by HHSC 's IGT Guidelines.

Project Goals: Goals will include increasing access to West Texas Centers Mobile Crisis Outreach team for emergency room, law enforcement personnel as well as individuals in the communities West Texas Center serves in RHP 12. In FY 2012 West Texas Centers received over 800 crisis calls for the RHP 12 West Texas Center counties with over 500 being legitimate "go mobile" response situations. The current Mobile Crisis Outreach team is responding to calls throughout the very rural and vast coverage area of the West Texas RHP 12 counties. Additional assessment of the West Texas Centers crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. West Texas Centers currently provides these crisis services with only one Mobile Crisis Outreach staff member in the RHP 12 service area. This one person is responsible for responding to the crisis call within one hour of notification on a 24/7 call rotation. This project would increase by 1.0 FTE the available Mobile Crisis Outreach Worker staff. West Texas Center's serves a primary population of Medicaid and uninsured patients. This project is expected to serve roughly 45% Medicaid and 54% uninsured with the remaining percentage of patients having some form of third party insurance; however, because we are the public safety net for behavioral health, the target population for this project would include any person in the WTC service area experiencing a psychiatric emergency and accessing the WTC crisis hotline. West Texas Centers will begin implementation activities in DY 3 through recruitment and hiring of an additional Mobile Crisis Outreach Worker. Improvement milestones will also begin in DY 3 when the project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 266 diversions or 266 persons diverted annually. DY 4 will see 20% or 290 persons annually diverted and by DY 5 the utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 326 diversions or 326 persons diverted annually. This project will enable WTC to improve our crisis response time providing intervention in the crisis event, in many cases avoiding an inappropriate hospital admission or incarceration. Increasing our ability to potentially intervene in a behavioral health crisis prior to the consumer being booked into the jail, admitted to the ED or taken to a psychiatric hospital for admission will have a significant impact on consumer quality of life, and quality of care as well as provide a much more cost effective treatment alternative. Follow up with patients who have experienced a mental health crisis event is a critical component in preventing repeat crisis situations. WTC currently has very limited resources to provide this follow up. This project will provide additional resources to increase and improve crisis support services related to prevention, wrap around, case management and other "support" type services necessary to maintain patient stabilization. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. This population will include those persons experiencing an emergency psychiatric condition. We do not believe the project duplicates another provider's intervention for the same target population.

Project Challenges: Challenges will include continued difficulty in recruitment of professionals and paraprofessionals to this very rural area. West Texas Centers will increase recruitment activities to include a sign on bonus and/or housing stipend if necessary

and will widen the recruitment area. The addition of a Mobile Crisis Outreach staff member will improve the ratio of crisis calls to staff member which in turn will improve recruitment and retention of staff in this high stress, high travel, critical decision making position. Additional challenges will include administrative support cost associated with gap analysis and assessment activities to determine current and future crisis system design needs. West Texas Centers plans to utilize highly qualified administrative personnel to design survey instruments and conduct the assessment activities. Also the Center will utilize professional software packages as needed to obtain the consumer data necessary for a complete crisis system assessment.

Five Year Expected Outcome: West Texas Centers anticipates meeting all core component requirements, milestones and metrics within the project by completion of demonstration year 5. It is expected this project will increase West Texas Center's capacity to provide cost effective and appropriate behavioral health intervention, triage and intensive wraparound services for individuals experiencing a psychiatric crisis. This project will also increase WTC ability to provide appropriate treatment alternatives to incarceration for individuals with low level charges and serious psychiatric impairment, reduce emergency department utilization and wait times for individuals experiencing a psychiatric crisis, ensure appropriate triage and maximization of psychiatric inpatient resources and maximize law enforcement time and resources by providing behavioral health crisis intervention services and assessment "real time" in the community. In DY 3 the project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 266 diversions or 266 persons diverted annually. DY 4 will see 20% or 290 persons annually diverted and by DY 5 the utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 326 diversions or 326 persons diverted annually.

Relationship to Regional Goals: This project will work to transform health care delivery from a disease focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of the existing behavioral health care system; and infrastructure, is responsive to patient needs throughout the region and improves health care outcomes and patient satisfaction.

Starting Point/Baseline: Baseline encounter data will be obtained from WTC fiscal year 2012 records as well as other data relevant to this project. WTC will continue to refine baseline data during DY 2.

Rationale: This project addresses RHP 12 Rural Community Needs Assessment number CN.2; severe lack of mental health services, inability to get an appointment, lack of insurance, and need to use ERs for initial contact will be specifically addressed through this project. West Texas Centers currently has one Mobile Crisis Outreach staff member covering the seven counties in RHP 12. With over 500 FY 2012 "go mobile" crisis calls, the ongoing ability to provide timely intervention and assistance to consumers and community stakeholders is tenuous. Staff turnover, recruitment challenges, travel requirements, and training needs continue to increase. West Texas Centers is currently proposing an expansion of its telemedicine services to provide additional psychiatric support to its front line crisis staff but without increasing the number of front line staff this assistance will not fulfill the crisis needs of the community. Ongoing assessment of our crisis delivery system is necessary to insure the most up to date and cost effective

processes are in place. Additional staffing increases will increase diversions from emergency rooms and law enforcement while providing faster more real time assistance to the consumer. Community needs assessment identified a lack of available behavioral health services in the region and as a result patients are entering the system through the emergency department door. This project was selected to provide improved response times to crisis services in the hope that more often the treatment options selected are more appropriate to the patient condition. Crisis services are high risk, high need situations. In these very rural areas providing that service must be done with well trained, well seasoned and extremely competent staff. This project will provide additional staffing resources to insure these needs are met. Required components of this project are: a) convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps; b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service; c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings; d) Explore potential crisis alternative service models and determine accept feasible models for implementation; e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project. This will be accomplished through utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring. Through the project descriptions, goals and rationale described in this document, West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project.

Milestones and Metrics:

Process milestones for this project are those identified for project option 1.13.1(Cat1, pg 141). WTC will conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. Additionally during DY 2 WTC will conduct mapping and gap analysis of the current crisis system resulting in a written plan identifying baseline and quality improvement initiatives related to WTC crisis services. West Texas Centers will utilize current administrative staff to design and develop tools and measurements to

perform ongoing quality management assessments through the life of the project. These will include conducting stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers to develop a gap analysis of WTC crisis response system. Improvement milestones were chosen to demonstrate an increase in the utilization of appropriate crisis alternatives. CQI feedback will be utilized to provide real time program resolution. West Texas Centers will begin implementation activities in DY 3 through recruitment and hiring of an additional Mobile Crisis Outreach Worker. Improvement milestones will also begin in DY 3 when the project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 266 diversions or 266 persons diverted annually. DY 4 will see 20% or 290 persons annually diverted and by DY 5 the utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 326 diversions or 326 persons diverted annually.

Community Needs Identification Number the Project addresses: RHP 12 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lock of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP.

New or Enhanced Initiative: This project is an enhancement to the current crisis service network West Texas Centers currently operates in these counties. Expansion of the Mobile Crisis Outreach staff will significantly enhance WTC's ability to respond more timely to crisis events as well as assist local emergency departments and law enforcement to divert crisis patients to more appropriate treatment settings.

Related Category 3 Outcome Measure(s): The process milestone selected for DY 2 was: P-1(Cat 3 pg 363): Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Process measure P-4(Cat 3 pg 363): Conduct Plan Do Study Act (PDSA) cycle to improve data collection and intervention activities was selected for DY 3. The planning component will be the primary emphasis for WTC during DY 2. This project is expected to serve roughly 45% Medicaid and 54% uninsured with the remaining percentage of patients having some form of third party insurance; however, because we are the public safety net for behavioral health, the target population for this project would include any person in the WTC service area experiencing a psychiatric emergency and accessing the WTC crisis hotline.

Inappropriate incarceration of persons experiencing a mental health crisis is detrimental for the patient and law enforcement, but is rapidly becoming the norm unfortunately as behavioral health crisis services are so limited in the rural area. Due to extremely limited hospital capacity for psychiatric emergencies, WTC continually works to provide appropriate diversions from hospitalization. Additionally, WTC works closely with all law enforcement and the court systems throughout the region to address the issue of persons who may have committed minor misdemeanor offenses but have been unable to access crisis personnel in time to avoid the arrest, thus filling jails to capacity and soaking up precious time and resources from our area law enforcement and legal systems. For these reasons WTC has selected for demonstration years 3-5, Improvement Target IT-9.1(standalone measure): Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (standalone measure). Baseline for

these targets will be related to diversion and incarceration data from WTC FY 2012, gap analysis data from DY 2 and information obtained from PDSA cycles in DY 3.

Improvement Targets for DY 4 and DY 5 will be:

- DY4-IT-9.1:Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population
- DY5-IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population.

Relationship to other Projects: West Texas Center's RHP 12 is also proposing a Dawson County behavioral health and primary care integration project number 130725806.2.15.2 as well as 130725806.1.1 a telemedicine expansion project.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Project will decrease cost of care through increase diversion of consumers from emergency rooms and jails as well as decrease the cost of inpatient care through inappropriate admissions to psychiatric facilities. As an example, regional hospital data indicates a 3 day hospitalization stay for a behavioral health admission is estimated to run $15,000. For a single crisis patient diverted to a more appropriate crisis alternative than a hospitalization the $15,000 cost savings would be significant but would in all probability be much higher due to the patient being supported by a team specifically trained for crisis intervention and follow-up. The project will meet the waiver goals additionally through more right care, right setting and right time treatment provision.	**9**
Addresses Community Need(s)	Project will increase access to crisis response services through additional Mobile Crisis Outreach team members. It will decrease response times for these staff to assist emergency rooms and law enforcement agencies with mental health crisis situations.	**6**
Project Scope/Size	Provider will conduct stake holder meetings, among consumers, family members, law enforcement, medical staff, social workers from emergency departments, EMS providers, psychiatric hospitals and relevant community behavioral health providers within the RHP 12 area. Provider will conduct mapping and gap analysis of current crisis system, recruit, hire and train additional Mobile Crisis Outreach staff. Improvement milestones will begin in DY 3 when the project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 266 diversions or 266 persons diverted annually. DY 4 will see 20% or 290 persons annually diverted and by DY 5 the utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 326 diversions or 326 persons diverted annually. This project will enable WTC to improve our crisis response time providing intervention in the crisis event, in many cases avoiding an inappropriate hospital admission or incarceration. Increasing our ability to potentially intervene in a behavioral health crisis prior to the consumer being booked into the jail, admitted to the ED or taken to a psychiatric hospital for admission will have a significant impact on consumer quality of life, and quality of care as well as provide a much more cost effective treatment alternative. Follow up with patients who have experienced a mental health crisis event is a critical component in preventing repeat crisis situations. WTC currently has very limited resources to provide this follow up. This project will provide additional resources to increase and improve crisis support services related to prevention, wrap around, case management and other “support” type services necessary to maintain patient stabilization.	**8**
Project Investment	Project will require significant cost related to recruitment, hiring, and training of additional staff. It will also require ongoing cost related to staff retention, travel expense and support services. Project will also require potential purchase of additional software related to consumer survey development. Public outreach and community forum cost will also be incurred.	**7**

130725806.1.2	1.13.1	1.13.1.a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
West Texas Centers			**130725806**
Related Category 3 Outcome Measure(s):	**130725806.3.3**	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons(standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1 **(cat 1, pg 142)** **Milestone:** Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. **P-1.1. Metric:** Number of meetings and participants. **Data Source:** Attendance lists **Baseline:** though previous stakeholder meetings have occurred, it is anticipated these meetings in DY 2 will specifically target crisis services therefore no baseline exists for this milestone. **Goal:** Will conduct a minimum of 2 stake holder meetings. **Milestone 1 P-1:** **Estimated Incentive Payment:** $56,734.50 **Milestone 2** **P-2(Cat 1, pg 142)** **Milestone:** Conduct mapping and	**Milestone 3** **P-4(Cat 1,pg 143)** Milestone: Hire and train staff to implement identified crisis stabilization services. P-4.1 Metric: Number of staff hired and trained. Data Source: Staff rosters and training records, training curricula Baseline: FY12 WTC Human Resource records for project area MCOT staffing Goal: Hire and/or identify 1.0 FTE staff member to perform Mobile Crisis Outreach Team (MCOT) functions for project area. **Milestone 3**: Estimated Incentive Payment: 56,658.50 **Milestone 4: I-12** **(Cat 1, pg 146)** Utilization of appropriate crisis alternatives **I-12.1. Metric**: **10%** increase in utilization of appropriate crisis alternatives.	**IMilestone 5: I-12** **(Cat 1, pg 146)** Utilization of appropriate crisis alternatives **I-12.1. Metric**: **20%** increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there was an increase. **Data source:** Claims, encounter, and clinical record data. **Baseline:** West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources **Goal:** Will increase the utilization of appropriate crisis alternatives by 2**0**% from DY 2 baseline for a total of **290** diversions or **290** persons diverted annually.	**Milestone 6: I-12** **(Cat 1, pg 146)** Utilization of appropriate crisis alternatives **I-12.1. Metric**: **35%** increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there was an increase. **Data source:** Claims, encounter, and clinical record data. **Baseline:** West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources **Goal:** Will increase the utilization of appropriate crisis alternatives by **35**% from DY 2 baseline for a

130725806.1.2	1.13.1	1.13.1.a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	
West Texas Centers			**130725806**	
Related Category 3 Outcome Measure(s):	**130725806.3.3**	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons(standalone measure)**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
gap analysis of current crisis system. **P-2.1. Metric:** Produce a written analysis of community needs for crisis services. **Data Source:** Written plan **Baseline:** WTC has not previously conducted a mapping or gap analysis specifically related to crisis services therefore no baseline exists for this milestone. **Goal:** Will conduct a mapping and gap analysis of current crisis system to determine baseline and identify improvement strategies. **Milestone 2 Estimated Incentive Payment:** $56,734.50	a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there was an increase. **Data source:** Claims, encounter, and clinical record data. **Baseline:** West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources **Goal:** Will increase the utilization of appropriate crisis alternatives by **10**% from DY 2 baseline for a total of **266** diversions or **266** persons diverted annually. **Milestone 4 Estimated Incentive Payment:** $ 56,658.50		**Milestone 5: Estimated Incentive Payment:$115,359.00**	total of **326** diversions or **326** persons diverted annually. **Milestone 6: Estimated Incentive Payment:$107,159.00**
Year 2 Estimated Milestone Bundle Amount: $113,469.00	Year 3 Estimated Milestone Bundle Amount: $113,317.00		Year 4 Estimated Milestone Bundle Amount: $115,359.00	Year 5 Estimated Milestone Bundle Amount: $107,159.00
Total Estimated DSRIP Funding for 4 Years :$449,304				

130725806.1.2	1.13.1	1.13.1.a-e	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
West Texas Centers			130725806
Related Category 3 Outcome Measure(s):	130725806.3.3	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons(standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)

Project Option: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region

Performing Provider: Yoakum County Hospital - 137227806
Unique Identification Number: 137227806.1.2 – "PASS 3b"
Project Components: 1.7.1.a-b

Provider: Yoakum County Hospital (YCH) is a 24-bed Critical Access Hospital serving Denver City and Plains in Yoakum County (with approximately 8,000 residents in the county) and several surrounding communities (serving a draw area of over 25,000 from western Texas to the bordering areas of eastern New Mexico). Outpatient dialysis, home health, outpatient/inpatient hospital care, emergency/surgery services, and physician clinic services are offered in Denver City by the Yoakum County Hospital healthcare team.
Interventions: The anticipated outcome is increased mental health services will yield more optimal and cost effective outcomes for Medicare/Medicaid/commercial insurance patients. This will also contain costs for patients that would have to travel close to 200 miles roundtrip for a physician visit.

Need for the project: Mental health services and family counseling are not readily available to Yoakum County residents. Family practice physicians are being asked by their patients to give family counseling without formal training and patients must drive close to 200 miles roundtrip for specialty services. This project was selected because it represents a great need in Yoakum County and it is one of the top priorities for all physicians and non-physician providers at Yoakum County Hospital.

Target Population: Medicaid, Medicare, and commercial insurance patients with adult psychiatry and adult/pediatric counseling needs. Approximately 32% of the West Texas Medical Center population is Medicaid and approximately 28% of the Plains Clinic patients are considered Medicaid.

Category 1 or 2 expected patient benefits: Access to counseling and mental health services without having to drive 200 miles roundtrip for every patient. Increase access to mental health/counseling specialty care by 90unique patients per year in DY 5.

Category 3 Outcomes: IT-6.1 In DY3, YCH will establish baseline patient satisfaction scores by surveying our target population of new and established psychology and psychiatry specialist visits at the Plains Clinic and West Texas Medical Center (the two RHC's that YCH owns). Improvement targets will be TBD in DY2.

Project Title: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed in the region
Performing Provider: Yoakum County Hospital/137227806
RHP Unique Identification Number: 137227806.1.2 – "PASS 3b"
Project Components: 1.7.1.a-b

- **Project Description:**
  The goal for Yoakum County Hospital is to increase access to adult psychiatry and adult/pediatric counseling services for all new and established Medicaid, Medicare, and commercial insurance patients at West Texas Medical Center and the Plains Clinic. If there is continued demand for telemedicine, Yoakum County Hospital will expand access to other specialties. This project will include residents who live in the rural region of West Texas and eastern New Mexico over the next 5 years. Although telemedicine is not a new idea in the world of modern medicine, this will be innovative at Yoakum County Hospital. The hospital can expand its services to thousands of rural residents in west Texas and eastern New Mexico who do not have current access to a psychiatrist or psychologist. This will contain costs for patients that would have to travel close to 200 miles roundtrip for a physician visit. The anticipated outcome is increased mental health services will yield more optimal and cost effective outcomes for Medicare/Medicaid/commercial insurance patients. As a mental health HPSA, there is demand for more mental health services in Yoakum County.
  Patients are currently visiting West Texas Medical Center and the Plains Clinic seeking mental health treatment from Family Practice providers without specialized training. As a healthcare service provider, Texas Tech University Health Sciences Center will facilitate this project's success. As part of initializing the project, they will train our staff on the process of referring/setting patient appointments, visits, and follow-up care. West Texas Medical Center will lease a telemedicine cart, which connects to the internet with an acceptable upload speed for a clear provider presentation. The cart comes with a 32-inch monitor, high-quality video-conferencing camera, as well as handhelds such as the telephonic stethoscope, otoscope, and hand-held exam camera. As part of that agreement they will deliver, provide set up, perform tests, train our staff on its use, and provide software upgrades as required.

  The five year goal is to increase mental health treatment services by 90 unique patients per year by DY5while significantly reducing transportation expenses for our patients. YCH will see 15 telemedicine visits in DY 3, 30 telemedicine visits in DY4 and 90 telemedicine visits over baseline (zero) in DY5 for our targeted population. 32% of patients are Medicaid at West Texas Medical Center, 28% of patients are Medicaid at the Plains Clinic, 35% are Medicare, 25% are commercial, and 8% are uninsured. Region 12's goal is to fulfill as many of the identified regional needs as possible. This is related to the Region 12

Community Needs Assessment CN.2 - Lack of mental health services, inability to get an appointment, lack of insurance, and need to use ERs for initial contact – source: BRFSS data, survey, focus groups, DSHS data. This is considered a critical need by the Region 12 Community Needs Assessment.
In June 2011, studies indicated that nearly 80 million Americans live in a mental health professional shortage area (U.S. Health and Human Services Health Resources and Services Administration), and research shows telemedicine and telehealth in particular would greatly address several hurdles to securing mental health services. Additionally, research shows that internet based therapy and face to face was not statistically significant. A 2010 study (Journal of Clinical Psychiatry Vol. 71. No. 7) found that video teleconferencing was successful in treating post-traumatic stress disorder for 125 rural combat veterans. Researchers found that the video based management anger management therapy was just as effective as face to face care. In contrast, telemedicine has had its challenges and controversies and there are inevitable difficulties associated with the introduction of new systems and technologies. There are also some who fear they will lose their jobs, others who fear the unknown, and there is always the possibility of a technological glitch in computer bandwidth and connectivity (S Bagchi, Telemedicine in Rural India, 2006). Other concerns with this technology include the safety and security aspect and it is imperative that there is extensive training and a thorough intake and assessment process to protect a patient's privacy (A. Novotney, A new Emphasis on telehealth; 2011).

- **Starting Point/Baseline:** Telemedicine is a new initiative for Yoakum County Hospital. The baseline will be zero to start.

- **Rationale:** This is a new initiative and Yoakum County Hospital does not currently have telemedicine equipment or the current ability to provide telemedicine consults for patients. This project was selected because it represents a great need in Yoakum County and it is one of the top priorities for all physicians and non-physician providers at Yoakum County Hospital. Telemedicine in our specialty clinic will open our community to a broad range of specialties we would not be able to offer otherwise. Telemedicine will achieve both of the core project components. We will (a) provide patient consults by specialist as well as other types of health professionals using telemedicine. Relating to core component (b), we will conduct quality improvement for the project using methods such as rapid cycle improvement. Yoakum County Hospital will satisfy the Process Milestone (P-11) with participation in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. The implementation of telemedicine within our two RHC's (P-3) will happen in DY2 through a relationship with Texas Tech University Health Sciences Center. We will have access to their entire network of providers including a psychologist and psychiatrist. This milestone (P-3) in DY2 was chosen because it allows us to quickly expand access to specialty care to meet the local and regional mental health needs. The improvement

milestone (I-12) is to increase the number of telemedicine visits for our target population to 90 unique patients in DY5. With the goal of increased access, this milestone makes sense by increasing the number of mental health visits.

- **Core Components:**
  - Patient consults by specialist will be available to the Plains Clinic and West Texas Medical Center. Yoakum County Hospital may also expand the services to Medicaid children who need to see a dermatologist if we find value in the child and adult counseling and adult psychiatry.
  - YCH will use the PDSA method and include monthly meetings in the hospital Quality Assurance formal meetings and give a report to the Medical Staff each month. Improvements to the program will be studied by the formal QA Quality Committee and findings will be presented to the Board of Directors each quarter.
  - YCH will also find a vendor that can measure CG CAHPS for both Rural Health Clinics, which will help determine the increase in patient satisfaction scores related to category 3.
  - **Unique Community need identification numbers the project addresses:**
    - CN.2 - Lack of mental health services, inability to get an appointment, lack of insurance, and need to use ERs for initial contact.
- **Related Category 3 Outcome Measure(s):** 137227806.3.3 OD-6 Patient Satisfaction IT-6.1 will be the outcome measure for category 3. We will use the CG CAPHS for West Texas Medical Center and the Plains Clinic. Yoakum County Hospital selected patient satisfaction because patient care is why our healthcare system exists. The ability to see a psychiatrist or psychologist with telemedicine, should lead to reduced travel times and more optimal access to specialists. This will translate into more optimal patient satisfaction.

Relationship to other Projects: This project is related to 2.6.2 in the sense that it is new to Yoakum County Hospital, involves new research and best practices, they both serve Medicaid patients, and the projects meet a community and regional need. Introducing telemedicine is related to category 3.6.1 because it enhances customer service to our Rural Health Clinics and Yoakum County Hospital. Introducing telemedicine is also related to preventing readmissions for mental health reasons and potentially keeping patients from utilizing the ER for mental health issues as well. This project is related to other facilities that are introducing telemedicine in the RHP. It is also related to expansion of mental health services in the region and preventing mental health ER visits by utilization of telemedicine. This project supports and enables patients to have cost-effective mental health services close to home without having to drive 200 miles roundtrip, thus reducing patient costs and providing better customer service in the region. 137227806.2.1 is related to introducing telemedicine if the Plains Clinic and West Texas Medical Center want to use technology to perform diabetic self-management education or follow up visits.

- **RELATIONSHIP TO OTHER PERFORMING PROVIDER PROJECTS AND PLAN FOR LEARNING COLLABORATIVE**
  RHP 12 will encourage participation by all of our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. There will be an open forum on the RHP 12 web site, which will facilitate stronger communication between the regional hospitals with related projects.

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project promotes high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. Telemedicine will have a positive impact on Medicaid/Medicare/commercial insurance residents within the primary and secondary service areas at Yoakum County Hospital who typically travel great distances to seek specialty care. Telemedicine shows great potential to achieve a triple aim. The five year goal is to see 90 unique patients per year by DY5.	**5**
Addresses Community Need(s)	Yoakum County Hospital valued this project at a 4 because it meets the local physician needs and regional needs. Increased access to mental/behavioral health is a top need in Yoakum County and the region. Medicaid/Medicare/commercial insurance patients will not have to travel such long distances to see their physician. This should increase access and specialty care options by partnering with Texas Tech Health Sciences Center, increase customer satisfaction, and reduce travel expenses for patients.	**4**
Project Scope/Size	Telemedicine will serve western Texas and eastern New Mexico within 45 miles of Denver City. This project will expand patient choice and provide more specialties to Yoakum County and beyond. Increased telemedicine visits will yield better access for mental health patients and counseling resources. This will decrease expenses for patients and promote better medication management for psychiatric care.	**4**
Project Investment	Yoakum County Hospital will need to invest in patient satisfaction decision support information technology and telemedicine equipment for two Rural Health Clinics. This project should be cost-efficient and impact the primary and secondary service areas at Yoakum County Hospital. The introduction of telemedicine to Yoakum County and beyond will “move the dial” in the right direction. We will also have to invest in measuring CG CAHPS for both Rural Health Clinics.	**3**

137227806.1.2 – "PASS 3b"	1.7.1	1.7.1.a,b	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed in the region	
Yoakum County Hospital				137227806
Related Category 3 Outcome Measure:	137227806.3.3		3.IT-6.1	Percent Improvement over Patient Satisfaction Scores
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-3 Implement or expand telemedicine program for new and established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Metric 1: P-3.1** Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR docs. **Data Source:** Program materials **Estimated Milestone 1 Incentive Payment:** $127,293.50 **Milestone 2: P-11** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-11.1** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes.	**Milestone 3: I-12** Increase number of telemedicine visits for new and established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Metric 1: I-12.1** Number of telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Baseline/Goal:** Baseline is zero patients served with telemedicine. Increase telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic by 15 patients over baseline. **Data Source:** EHR or electronic referral processing system, encounter records from telemedicine program.		**Milestone 5: I-12** Increase number of telemedicine for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Metric 1: [1.7.1-I-12.1]:** Number of telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Baseline/Goal:** Baseline is 15 patients from DY 3served with telemedicine. Increase telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic by to 30by DY4. **Data Source:** EHR or electronic referral processing system, encounter records from telemedicine program.	**Milestone 7: I-12** Increase number of telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Metric 1: I-12** Number of telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic. **Baseline/Goal:** Baseline is 30 from DY4 patients served with telemedicine. Increase telemedicine visits for new & established Medicaid/Medicare/commercial insurance patients regarding psychology counseling and psychiatric needs at West Texas Medical Center & the Plains Clinic to 90 unique patients in DY5. **Data Source:** EHR or electronic referral processing system, encounter records from telemedicine program.

137227806.1.2 – "PASS 3b"	1.7.1	1.7.1.a,b	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed in the region	
Yoakum County Hospital				137227806
Related Category 3 Outcome Measure:	137227806.3.3		3.IT-6.1	Percent Improvement over Patient Satisfaction Scores
Estimated Milestone 2 Incentive Payment: $127,293.50	**Estimated Milestone 3 Incentive Payment:** $141,247.50 **Milestone 4: P-11** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-11.1** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 4 Incentive Payment:** $141,247.50		**Estimated Milestone 5 Incentive Payment:** $135,805.50 **Milestone 6: P-11** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-11.1** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 6 Incentive Payment:** $135,805.50	**Estimated Milestone 7 Incentive Payment:** $111,866.50 **Milestone 8: P-11** Participate in face-to-face learning with other providers in RHP with similar projects. **Metric 1: P-11.1** Participate in semi-annual face- to- face meetings or seminars organized by the RHP. **Data Source:** Documentation of semiannual meeting including meeting agendas, slide presentations and/or meeting notes. **Estimated Milestone 8 Incentive Payment:** $111,866.50
DY 2 Estimated Milestone Bundle Amount: $ 254,587	**DY 3 Estimated Milestone Bundle Amount** $282,495		**DY4 Estimated Milestone Bundle Amount:** $271,611	**DY5 Estimated Milestone Bundle Amount:** $ 223,733
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,032,425				

D. Category 2: Program Innovation and Redesign

Project Option: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Performing Provider: Brownfield Regional Medical Center/130618504

Unique Identification Number: 130618504.2.2 – "PASS 3b"

Project Components: 2.9.1.a-e

Provider: Brownfield Regional Medical Center (BRMC) is an acute care facility operating under Terry Memorial Hospital District. BRMC is currently staffed for 26 beds but is licensed for 45 beds. BRMC's primary service area is Terry County, but secondary service area extends to surrounding counties and parts of eastern New Mexico. The total service area population is estimated at around 28,000.

Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.

Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.

Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 200 non-urgent patients without a primary care provider to a primary care provider while in the ED each year with a Medicaid and indigent share of at least 20%.

Category 1 or 2 Expected Patient Benefits: BRMC's expects to refer 11% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 276 patients. Patients will benefit from access to a primary care provider and follow-up care.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 2% in DY 4 and 4% in DY 5.

Project Option: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Performing Provider: Brownfield Regional Medical Center/130618504
Unique Identification Number: 130618504.2.2 – "PASS 3b"
Project Components: 2.9.1.a-e

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. BRMC's goal is to refer 5% of non-urgent patients without a primary care provider to a primary care provider while in the ED in DY 3, followed by 8% and 11% in DY 4-5, respectively.

Through our Patient Navigation Program, BRMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, BRMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

The overall vision for the Region 12 RHP is to assure residents receive high-quality, patient-centered care, in a cost effective manner that focuses on coordinated care delivery and improved health outcomes, with a particular focus on the Medicaid and uninsured residents, while containing cost growth. BRMC is partnering in the region's vision to fulfill as many of the community needs identified in the area as possible focusing on those identified as urgent and critical needs. These include improving quality and performance, increasing access to care, and increasing prevention and early detection activities. In order to meet the healthcare needs of our population within Northwest Texas, BRMC is proposing to provide navigation services to ED patients who are disconnected from primary care. Navigating non-urgent ED patients to the primary care setting meets three community needs outlined by RHP 12, including: severe primary care provider shortage, wait time, expense, lack of insurance, access to care **(CN.1)**, poor insurance support or uninsured **(CN.3)**, and high incidence of obesity, diabetes mellitus and heart disease **(CN.4)**.

BRMC will meet all the required core project components by B) deploying registered nurses or nurse practitioners as patient navigators. A) These nurses will be tasked to identify frequent ED users. C) BRMC will use these navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. D) Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. E)

Finally, BRMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures. The project description above describes how each of the project core components will be implemented.

Starting Point/Baseline: BRMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. BRMC saw approximately 5,855 emergency room visits in 2012—including 2,509 non-urgent visits (42.9%). While BRMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 BRMC		
ED Level	**ED Visits**	**Percent**
Level 1 (Immediate)	107	1.8%
Level 2 (Emergent)	598	10.2%
Level 3 (Urgent)	2,435	41.6%
Level 4 (Semiurgent)	2,054	35.1%
Level 5 (Nonurgent)	455	7.8%
No Triage	206	3.5%
Total Visits	**5,855**	100.0%
Non-Urgent Visits	**2,509**	**42.9%**

Rationale: As sited in the community needs assessment (CN.1 and CN.4), there is a widespread critical need and shortage of primary care capacity and access and chronic disease management. Our new initiative of using ED navigators to shift patients to the clinic setting will meet all the required core project components by expanding access to primary and preventive care, improving access to chronic disease management, decreasing utilization of more costly care, and improving the quality of care given to truly emergency patients in the ED.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)." In

addition, the 2009 National Hospital Ambulatory Medical Care Survey found that approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic.

The expected outcome of our milestones and metrics is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows BRMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow BRMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite BRMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit. Implementing this program will have an estimated annual savings of $145,393.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		2,509
% Clinic Appropriate		11%
Clinic Appropriate Patients		276
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**186,401**
Clinic Payment @ 78% savings	$	41,008
Total Estimated Savings	**$**	**145,393**

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)
(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)
Related Category 3 Outcome Measure(s): The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). BRMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 2% in DY 4 and 4% in DY 5. It is important to note that it is our belief that both this project to develop a patient navigation service and our second project to expand primary care clinic hours and capacity will both serve to reduce ambulatory care sensitive conditions admission rates, but each has its own goal.

We propose to increase the overall quality of care and improve the health status of our target population—new BRMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

Relationship to other Projects: BRMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. Per BRMC's Pass 1 project plan, the BRMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (IT-2.11) due to enhanced physician-patient relationships and preventive care.

Relationship to Other Performing Providers' Projects in the RHP: BRMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Furthermore, our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP.

Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • Our ED navigation program will assure that patients receive high-quality and patient-centered care, in the most cost effective ways. Providing primary care in the clinic setting is certainly the most cost effective—much more efficient than the ED or inpatient hospitalization. Establishing ED navigators will create a patient-centered mindset and will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. • Primary care will better serve the Medicaid and uninsured residents of the greater Brownfield community much more effectively than the ED—having access to follow-up and preventive care. Performing Providers may consider the following attributes when scoring projects on this domain: • This project primarily impacts Medicaid and/or uninsured residents since this population is most likely to receive	**5**

Criteria	Narrative	Score (1-5)
	primary care in the ED and be disconnected from a primary care provider. ED navigation and connecting patients to primary care providers will move the dial considerably to expand primary care access. • An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)." In addition, the March 2012 Executive Newsletter for HealthGrades reported that WellPoint, Inc. beneficiaries "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." The evidence of decreased admissions and ED visits revealed in these primary care based pilots shows that preventive care can lead to lower overall utilization and cost. (Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)	
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? • As sited in the community needs assessment (CN.1 and CN.4), there is a widespread critical need and shortage of primary care capacity and access and chronic disease management. ED navigators shifting patients to the clinic setting will expand access to primary and preventive care, improve access to chronic disease management, decrease utilization of more costly care, and improve the quality of care given to truly emergency patients in the ED.	**5**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? • BRMC expects to navigate about 600 visits to the clinic setting. Considering the small population (~18,600) of Terry County, that is a considerable degree of primary care expansion and ED savings. • The March 2012 Executive Newsletter for HealthGrades reported that WellPoint, Inc. beneficiaries "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." The evidence of decreased admissions and ED visits revealed in these primary care based pilots shows that preventive care can lead to lower overall cost.	**5**
Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? • ED Navigation and triage protocol will require additional RN and clerical staffing. It will also require additional IT and overhead expenses for reporting category 3 measures. Since we have no other projects, the relative investment is high.	**5**

130618504.2.2 – "PASS 3b"	***2.9.1***	***2.9.1.A-E***	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Brownfield Regional Medical Center			***130618504***
Related Category 3 Outcome Measure(s):	***130618504.3.3***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*

Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $237,756	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [126] out of a baseline of 2,509 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $263,820	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 8% [201] out of a baseline of 2,509 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $253,653	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 11% [276] out of a baseline of 2,509 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $208,942
Year 2 Estimated Total DSRIP: $237,756	Year 3 Estimated Total DSRIP: $263,820	Year 4 Estimated Total DSRIP: $253,653	Year 5 Estimated Total DSRIP: $208,942

130618504.2.2 – "PASS 3b"	***2.9.1***	***2.9.1.A-E***	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Brownfield Regional Medical Center			***130618504***
Related Category 3 Outcome Measure(s):	***130618504.3.3***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
TOTAL EST DSRIP FUNDING FOR 4 YEARS*:* ***$964,171***			

Option: 2.15.1 Design, Implement, and evaluate projects that provide integrated primary and behavioral health care services
Performing Provider: Central Plains Center/127374005
RHP Unique Identification Number: 127374005.2.1
Project Components: 2.15.1.a-j
Provider: Central Plains Center, CPC, will be the provider. CPC is a community-based mental health and intellectual disabilities center serving 9 rural and frontier counties which is 10,000 square miles and approximately 92,000 people. We provide mental health services to on average 465 adults and 125 children. We also provide intellectual disability services to 120 individuals. CPC also offers early intervention services to babies, birth up to 3 years of age and residential substance abuse treatment for adolescent boys. In our RHP, we are the only provider of these specific services in our nine-county service area.
Interventions: The interventions will specifically be the behavioral health professional providing mental health services in a primary care setting, as well as consulting with primary care physicians on patients who present with mental health issues. Additionally, we will provide behavioral health services in the emergency room, including brief therapeutic services and screening/referrals. The idea is to provide services in a whole-health approach in a single treatment environment instead of the traditionally separated treatment locations. By doing so, we seek to reduce the number of people utilizing emergency room services inappropriately.
Need for the project: The National Institute of Mental Health (NIMH) states in a 2008 report that an estimated 26.2% of adult Americans, about one in four, suffer from a diagnosable mental disorder in a given year. This translates to 57.7 million people nationally. CPC selected this project for the purposes of making behavioral health services and supports available in a primary care setting. In a twelve-month period, Covenant Hospital of Plainview served over 300 people in the emergency room who were flagged as presenting with a mental health issue. This project will seek to serve individuals such as these in a manner that would reduce emergency room use and result in a healthier life.
Target Population: This project targets individuals from age 4 to adults 18 years and older who are treated in the Covenant Rural Health Clinic for physical issues and present with symptoms that could be a result of a mental health issue. Our project will target approximately 300 patients of the clinic of the emergency room over the course of the project. The Rural Health Clinic's patient mix included 33% Medicaid recipients and 2% indigent. We expect them to receive 35% of the interventions. Additionally, the project targets individuals who present in the ER with potential mental health issues where a brief mental health intervention could prevent an impatient stay or costly ER services.
Category 2 expected patient benefits: This project initially is specific to one county with a population of 36,000. We will establish a baseline for potential number of interventions in DY 2 and 3 after establishing service standards and protocols. We seek to serve 7% of the baseline in DY 4 and 15% in DY 5 as well as expand the availability to our other rural/frontier counties.
Category 3 outcomes - TBD

Project Option: 2.15.1 Design, Implement, and evaluate projects that provide integrated primary and behavioral health care services
Performing Provider: Central Plains Center/127374005
RHP Unique Identification Number: 127374005.2.1
Project Title: Service Integration Project

Project Components: 2.15.1.a-j

Project Description:
Central Plains Center is partnering with Covenant Hospital Plainview to place a behavioral health professional into one primary care clinic with the goal of integrating behavioral health and primary care services. The behavioral health professional will also be available, and closely located, to the Emergency Room for the purpose of consultations and possibly behavioral health interventions. Ultimately, the behavioral health professional would be part of an overall team, treating the patient holistically and work hand-in-hand with treating physicians and nurses. The BH Professional will provide an on-site referral source for primary care personnel as well as providing educational services to the general public and primary care professionals regarding behavioral health issues.

- This project will integrate what have historically been two separate health care fields, mental and physical, by unifying the treatment goals of each field in treating individuals holistically.
- Potential areas of improvements are significant around the area of communication between these disciplines. By integrating these services we will drastically improve the spread of information for the purpose of improving patient care and health outcomes.
- The healthcare team will be made up of the Chief Executive Office, Chief Services Officer, Chief Financial Officer of Central Plains Center, physicians and nursing staff at the Covenant Rural Health Clinic and the Covenant Emergency Room as well as the behavioral health professional to be hired as part of this project. Other team members may be added as program expands.
- The healthcare team's responsibilities will include planning for implementation, implementing procedures and protocols to ensure quality of services.
- This project will initially impact the Covenant Rural Health Clinic and the Covenant Emergency Room, both in Plainview, Texas. Additional clinics/locations may be impacted with program expansion.
- The project will ideally flow as part of the rural health clinic and not just a clinician in an office. The physicians will identify patients with potential mental health issues and consult and refer to the behavioral health professional. The emergency room staff will also consult and refer to the behavioral health professional when individuals present there with potential mental health issues. The behavioral health professional will also provide education to the staff at Covenant Rural Health Clinic and the Emergency Room.

- This project targets individuals from age 4 to adults 18 years and older who are treated in the Covenant Rural Health Clinic for physical issues and present with symptoms that could be a result of a mental health issue. Additionally, the project targets individuals who present in the ER with potential mental health issues where a brief mental health intervention could prevent an impatient stay or costly ER services.

Project Goals: The goal of this project is to integrate physical and mental health treatment in a single location instead of two different locations for the purpose of improved health outcomes for individuals while decreasing the cost for these services and preventing further treatment episodes.

- Decrease the number of individuals who present to the Emergency Room with metal health issues.
- Increase the number of individuals treated with a holistic approach at the Rural Health Clinic

Challenges: The challenges we face include managing a change of treatment approach for the physical care providers as well as the behavioral health professional. We believe that with consistent, open communication and sharing of a common goal will help us overcome this challenge. Another barrier will be overcoming a significant history of mental health and physical health being two entirely separate service systems. We hope to overcome this with education and information to the patients we serve as well as service providers. This program is a new initiative for our center and for Covenant Hospital Plainview as this treatment model has not been practiced in their health clinics or emergency room.

Five-Year Expected Outcomes: Our expected outcomes include reducing ER admissions for behavioral health purposes so that there will be less of a burden on Emergency Room resources. The behavioral health professional would be available to counsel those with diabetes, obesity issues, addiction, eating disorders, anxiety, depression, and any other behavioral health issues that could occur. Our overall desired outcome is to achieve a Level 4-5 of collaboration with this project.

Relationship to Regional Goals: As a region our goals are to fulfill all of the community needs identified on our regional needs assessment. This project aims to meet the community need indicating a lack of mental health services, inability to get an appointment, lack of insurance that result in the need to use emergency rooms for initial mental health contact. Our RHP has designated this as a critical need.

Unique community need identification numbers the project addresses:

- CN.2-Lack of mental health services

Starting Point/Baseline: Currently, integrated services do not exist for in our service area. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2.

Rationale: The National Institute of Mental Health (NIMH) states in a 2008 report that an estimated 26.2% of adult Americans, about one in four, suffer from a diagnosable mental disorder in a given year. This translates to 57.7 million people nationally. If that percentage were applied to Central Plains Center's service area that would mean that in our nine counties there are approximately 24,000 adults with a diagnosable mental illness on any given day. Add to this the fact that 17% of American adults have comorbid mental health and medical conditions. That results in approximately 15,640 adults in our service area that meet that criteria. (Druss, B.G., and Walker, E.R. (February 2011). Mental Disorders and Medical Comorbidity. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.) CPC selected this project for the purposes of making behavioral health services and supports available in a primary care setting. With limited state funding the availability of behavioral health services to the public is significantly scarce, especially in our rural setting. Our research and meetings with our potential partners, Covenant Hospital Plainview has shown that

1.) Emergency Room resources are often tied up treating what turns out to be anxiety or bereavement,
2.) Primary care physicians will benefit from being able to collaborate with a behavioral health professional on patients presenting with behavioral health problems and
3.) There is a need for brief therapeutic interventions or counseling with individuals receiving primary care services.

Required components:

a) Working closely with Covenant Hospital Plainview we will identify a site for the collaboration to take place that will benefit a significant number of patients in the community.
b) Once the site is decided upon, we will develop provider agreements that would allow for information sharing between the two entities.
c) Along with the provider agreements we will develop protocols and processes for communication, data-sharing and referrals between providers.
d) We will initially recruit and hire one behavioral health professional, most likely a Licensed Professional Counselor or a Licensed Clinical Social Worker.
e) Once hired, we will train both physical and behavioral health providers in the protocols, effective communication and the overall team approach. We will work on building a shared culture of treatment to include regular consultative meetings, case

conferences on individualized as needed basis to discuss individuals served by both type of providers and develop shared treatment plans that are collaboratively developed.

f) We will acquire data reporting, communication and collection tools to be used in the integrated setting, this will most likely include a health information exchange between our two electronic health records.
g) We will research and determine the need for any legal agreements.
h) Utilities and building services will be arranged.
i) And j): We will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individuals treated. Via our collaboration meetings we will conduct on-going quality improvement for the project. We will also explore the need and possibility of expanding this model into other counties in our service areas.

We selected milestones/metrics that we felt were relevant to our target population and community needs. We will identify existing clinics where integration could be supported. We will develop and implement standards of service that will allow us to increase access to physical and behavioral health care in our RHP. Our DY 4 and DY 5 milestones/metrics will allow us to track data that will show impact of integrated services for the individuals in our service area. We will track the percentage of individuals receiving both physical and behavioral health care at the established locations as well as track the percentage of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise.

Integrated services of behavioral health and physical health have not existed in our service area. This is a new initiative for our center and for Covenant Hospital Plainview.

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: This project will work closely with our Peer Provider Project for the purpose of ensuring the ease of referrals to PCP for consumers of mental health services. Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they

have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	The impact of this project could be far-reaching, especially with further expansion in the coming years. This project will provide high-quality of services by combining two approaches for the purpose of treating people holistically. The project will draw upon two disciplines of treatment with improved outcomes for patients as mental and physical health are interwoven. Medical cost offset may occur when patients use less medical care because they are receiving mental health services. The reduced physical health care cost offsets the cost of the mental health care (Strosahl and Sobel 1996). This project will connect what have, historically, been two separate service systems serving the same patients. This will improve the healthcare infrastructure to better serve the Medicaid and uninsured as well as developing and maintaining a coordinated care delivery system.	**5**
Addresses Community Need(s)	This project meets several of the identified community needs as documented in the Community Needs Assessment Summary for RHP 12 including lack of mental health services; need to use ER for initial contact, poor insurance support or uninsured as well as addressing the issue of high incidences of obesity, diabetes mellitus and heart disease in our service areas. We anticipate that through this integration many patients being served in the physical care clinic who receive integrated treatment will experience improved health statuses. In the document "Evolving Models of Behavioral Health Integration in Primary Care" by Chris Collins, Denise Levis Hewson, Richard Mungar and Torlen Wade there is documentation that shows the far-reaching benefits of an integrated care model. It cites cost benefits, health outcome benefits as well as being beneficial and applicable to patients of all ages.	**5**
Project Scope/Size	In the article "Valuing the Integrated Primary and Mental Health Clinic Project Center for Health Care Services: Texas Healthcare Transformation and Quality Improvement" Prepared by H. Shelton Brown, A. Hasanat Alamgir, UT Houston School of Public Health, Thomas Bohman and the UT Austin Center for Social Work Research, they found "The benefits of the proposed co-location program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard." This research demonstrates the potential cost savings this project could render.	**5**
Project Investment	This project will require more health care provider's to be involved than the other project. The project is setup to hire and train individuals to support the integrated health project. Our overall focus will be on behavioral health staff and PCP working together as a team in treating patients. We think at this time very little will be needed in equipment or maintenance to support this project. Meeting the time line in implementing this project, should be relatively simple because of the organization, legal, professional and staff support that is available. During this time we will be evaluating the risk assessment over the years and make adjustment as identified.	**5**

127374005.2.1	2.15.1	2.15.1.a-j	***Design, Implement, and evaluate projects that provide integrated primary and behavioral health care services***
Central Plains Center		**127374005**	
Related Category 3 Outcome Measure(s): TDB	**127374005.3.1**	**TBD**	**TBD**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-2. Milestone: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new Settings or for physicians to share their office space with behavioral health practitioners. . Metric: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. a. Data Source: Information from persons interviewed b. Goal: Designate clinic for integration to take place and have Emergency Room designated as well. Estimated Milestone 2 Incentive Payment: $563,174	P-3. Milestone: Develop and implement a set of standards to be used for integrated services To ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. P-3.1. Metric: Number and types of referrals that are made between providers at the location a. Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results P-3.2. Metric: Number of referrals that are made outside of the location a. Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results P-3.3. Metric: Number of referrals which follow the established standards	I-9. Milestone: Coordination of Care I-9.1. Metric: 7% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Data Source: Project data; claims and encounter data; medical records Goal: To have 7% of patient population have integrated treatment plan developed. Target is 80 Estimated Milestone 5 Incentive Payment: $ $628,502	I-9. Milestone: Coordination of Care I-9.1. Metric: 15% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise a. Numerator: Number of individuals with treatment plans developed and implemented with primary care and behavioral health expertise b. Denominator: Number of individuals receiving services at project sites. Data Source: Project data; claims and encounter data; medical records Goal: To have 15% of patient population have integrated treatment plan developed. Target is 150 Estimated Milestone 7 Incentive Payment: $607,249

127374005.2.1	**2.15.1**	**2.15.1.a-j**	***Design, Implement, and evaluate projects that provide integrated primary and behavioral health care services***
Central Plains Center		**127374005**	
Related Category 3 Outcome Measure(s): TDB	**127374005.3.1**	**TBD**	**TBD**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
	Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Goal: Development and implementation of service standards by providing integrated services to 35 individuals in this development year. *Estimated Milestone 3 Incentive Payment:* *$587,513*		
DY 2 Estimated Milestone Bundle Amount: $563,174	DY 3 Estimated Milestone Bundle Amount: $587,513	DY4 Estimated Milestone Bundle Amount: $628,502	*DY5 Estimated Milestone Bundle Amount: $607,249*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:$2,386,438			

Project Option: 2.18.1 Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.
Performing Provider: Central Plains Center/127374005

RHP Unique Identification Number: 127374005.2.2

Project Components: 2.18.1.a-i

- **Provider:** Central Plains Center, CPC, will be the provider. CPC is a community-based mental health and intellectual disabilities center serving 9 rural and frontier counties that covers 10,000 square miles and approximately 92,000 people. We provide mental health services to, on average, 465 adults and 125 children. We also provide intellectual disability services to 120 individuals. CPC also offers early intervention services to babies, birth up to 3 years of age and residential substance abuse treatment for adolescent boys. In RHP 12, we are the only provider of these specific services in our nine-county service area.
- **Interventions:** Our specific interventions will be working with mental health consumers in identifying health risks and referring these individuals to needed medical treatment by their primary care providers.
- **Need for the project:** We currently do not have any peer providers in our service area. Peer supported services have proven to be beneficial for consumers of mental health services. This project seeks to provide peer supported services for the purpose of addressing health needs in a population that is at risk for serious health issues due to lifestyle, medication side effects and other risk factors.
- **Target Population:** The target population for this project, specifically, is adults, ages 18+ who are currently receiving adult mental health services or need to receive mental health services who have unidentified health risks and needs. Our current Medicaid population is 31% and our indigent population is approximately 60% , so we estimate that they would benefit from 91% of the encounters. Our project will target approximately 410 patients in our mental health clinic.
- **Category 2 expected patient benefits:** This project seeks to provide health risk assessments on approximately 410 adults diagnosed with a mental illness. This project also seeks to provide whole health groups for these individuals as well as facilitate and follow through on referrals to primary care services for needed medical services. In DY 3 we will provide approximately 75 health risks assessments to consumers. DY 4 we seek to target approximately 200-250 consumers and in DY 5 we seek to target 300 of our mental health consumers.
- **Category 3 outcomes:** To be determined.

Project Option: 2.18.1 Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.
Performing Provider: Central Plains Center/127374005

RHP Unique Identification Number: 127374005.2.2

Project Components: 2.18.1.a-i

Project Description:

- We selected this project because we have a goal to help to improve our consumers' whole health instead of primarily concentrating on just the symptoms of a psychiatric diagnosis. This project will help us meet this goal. We will fully integrate two peer providers into our adult mental health service system with a goal of them taking on a supportive role with fellow consumers. We believe that a peer would be able to assist consumers in accessing needed physical medical treatment more effectively than other staff. We have participated in the Via-Hope Recovery Focused Learning Community as well as their Leadership Academy. Our final step in establishing a recovery-focused system of services is to hire peer specialists so that we can focus on treating the whole person.
- The healthcare team will be made up of our Chief Executive Officer, Chief Services Officer, Chief Financial Officer, Director of Mental Health Services, Coordinator of adult MH services and the Coordinator of our psychiatric clinic, as well as clinic staff, nurses and our psychiatrist. The two new peer providers will be an integral part of this team.
- This team will be responsible for hiring and obtaining training for our two new peer providers, identifying and implementing procedures for establishing the new program.
- We currently serve individuals in nine counties from our primary psychiatric clinic located in Plainview, Texas. We also have two telemedicine clinics with the remote locations in Littlefield and Muleshoe, Texas. This new project will impact each of these locations as well as any additional telemedicine remote sites that might be added in the future.
- We anticipate that the flow of the process will be initiated in our clinic. Our nursing staff currently performs routine vital checks and look to identify individuals' health needs. A referral will be generated at this point to the peer providers, who will then conduct a health risk assessment and assist in referring individuals to needed medical services and primary care providers. Each point of contact will be documented. Peers will work closely with our adult mental health case managers in procuring referrals for individuals to participate in whole health groups. These groups can and will be provided in local communities to ensure sufficient access to the service.
- Our project will target adults receiving mental health services or identified with mental health issues.
- The target population for this project, specifically, is adults ages 18+ who are currently receiving adult mental health services or need to receive mental health services.

Project Goals:
The goal of this project is to improve the overall health of individuals receiving adult mental health services in our center by enhancing access to medical services and treatment.

- We want to increase the number of adult receiving needed medical interventions to improve identified health risks
- We want to provide peer services as a preventative step to reduce the long-term loss due to untreated medical conditions.

Challenges:
Challenges include hiring the right people who have traits that would fit these positions and engaging our medical community in working with our peers by receiving referrals. The challenge of hiring the right people should be overcome by utilizing our adult mental health staff to help identify persons who would fit well in our positions. The challenge of engaging our medical community will be overcome actually by one of our other projects related to the integration of behavioral health and physical health. We plan on capitalizing on the relationships which that project will build. This is in line with our regional goals for increasing access to medical services. The expected outcome for this plan is for our consumers to begin and continue receiving needed medical treatment for the purpose of improving their overall health and to increase the likelihood of a more extended life than would have been expected without this project.

Five Year Expected Outcomes:
The expected outcome for this plan is for our consumers to begin and continue receiving needed medical treatment for the purpose of improving their overall health and to increase the likelihood of a more extended life than would have been expected without this project.

Relationship to Regional Goals:
Our RHP's goals are to fulfill all of the community needs identified on our regional needs assessment. The unique community needs this project addresses are CN.2 and CN.1 relating to a lack of mental health services and a lack of primary care providers available in our RHP. The RHP has designated this as a critical need and this project will address each issue simultaneously. This project helps develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patients needs throughout our service area and improves health care outcomes and patient satisfaction.

Starting Point/Baseline: Peer provided services have not been provided in our service area. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2.
Rationale: Research has proven that individuals diagnosed with a mental health disorder die on average 29 years younger than the general population. (Parks, J, Steenson, D, et.al. "Morbidity and Mortality in People with Serious Mental Illness"' National Association

of State Mental Health Program Directors, 2006) Peer providers are in the unique position to develop relationships with consumers of mental health services that traditional "professional" personnel are not. This relationship lends itself to a more trustful nature and research has proven the benefits of this. (Kim S. Griswold, MD, MPH, Patricia A. Pastore, FNP, Gregory G. Homish, PhD, and Angela Henke, Access to Primary Care: Are Mental Health Peers Effective in Helping Patients After a Psychiatric Emergency, 2010)

- Our project will include project options: a, c, d, e, f, g, h, and i. Project options are as follows:
  a) We will train administrative staff and key clinical staff on the use of peer specialists in order to get buy-in on all levels of our organization and area primary care physicians. This will be accomplished by conducting training at our center's program director's meetings and at staff meetings of targeted programs.
  b) We will not conduct a readiness assessment of our organization because we have been involved in the Recovery-Focused Learning Community with Via Hope since 2011, of which peer services is an integral part. We have a Licensed Professional Counselor who is trained by Via-Hope as a peer specialist supervisor; we also have two staff who are trained facilitators for the Wellness Recovery Action Plan. The Wellness Recovery Action Plan®, or WRAP®, is an evidence-based system that is used world-wide by people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness. It was developed by Mary Ellen Copeland, PhD. (Website is www.mentalhealthrecovery.com) We have had volunteer peers in the past however we were unable to keep them motivated without being able to hire them as employees. We believe our organization is ready for peer services without conducting a readiness assessment.
  c) We will work closely with our adult mental health staffs who work daily with our consumers to help identify potential persons who would be a good fit for these two positions. These are the staff who know our consumers and have helped them along in their recovery.
  d) Our current plan is for these two peer specialists to attend Certified Peer Specialist (CPS) Training and Whole Health training as provided by Via-Hope. We will also have the peers trained as WRAP facilitators when that training is made available.
  e) Our current plan is for the peers to be present during our psychiatric clinic hours in order to meet with consumers before or after their psychiatric appointments in order to conduct a health risk assessment for the purpose of identifying patients who have health risk factors that can be modified.
  f) The peers will work closely with our clinic nursing staff when the nurses identify patients with potential health risks.
  g) The peers will also provide WRAP planning sessions with consumers to help them develop plans of their own that will help and inspire them to recover and to improve their overall health.
  h) We will ensure that consumers with health risk factors are connected to primary and preventative care so they can be treated for any untreated medical conditions and to prevent future medical conditions.

i) We will track patient outcomes and use the data to provide continued project improvement measures to ensure the effectiveness of the project.

- Our milestones and metrics were selected by determining what measures were critical to the success of this project. Without being able to measure these milestones we could not ensure forward momentum towards accomplishing our goal or our regional goals. We selected specifically to train our administrative and clinical staff on peer provided services and to identify and train the peers for year one so that we could begin the projects as soon as we can. For DY 3 we chose the milestones as follows: select the health risk assessment tool and to implement the peer services so that we could begin having an impact on the health of our population to address the critical community needs. Our milestone for DY 4 is to track how many individuals are actually receiving the needed medical services identified on the health risk assessments. We selected this milestone so that we could measure the outcome of the project to identify the improvements in individuals' health. The milestone for DY 5 is to identify improved health measures across the population so that we could document improved health for the individuals participating in this project.

- This project is a new initiative for our center. We have participated in the Via-Hope Recovery Focused Service Delivery project and have not had the resources to hire peers to be providers. This incentive helps us to finally be able to hire two peers to fully realize the benefits of having peers as part of our service system.

Unique community need identification numbers the project addresses:

ID #	Description of problem needing to be addressed	Data Source
CN.1	Severe primary care provider shortage, wait time, expense, lack of insurance, access to care	BRFSS data, Focus groups, survey, DSHS
CN.2	Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.	BRFSS data, survey, focus groups. DSHS data

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: This project will work at times with our other project on integrating behavioral health and physical health services. It will be important for our peers to have good working relationships with members of our medical community in order to ensure ease of access to needed medical services. Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data

and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Relationship to Other Performing Providers' Projects in the RHP: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Plan for Learning Collaborative: N/A

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project meets the triple aim of assuring patients receive high-quality and patient-centered care in the most cost effective way most significantly by addressing health risks of mental health consumers before their health risks are a more costly burden on the health care system. This peer project will enhance the health care infrastructure by identifying adults with co-morbid mental health and physical health risks. This has not occurred n our service area before and it is a missing link. The peer project further develop and maintain a coordinated care delivery system by being an integral cog in the wheel of linking individuals with health risks to the needed health care. By using a peer to connect with mental health consumers will ensure outcome improvement and keep cost down by preventing future health issues in a high risk population that has been underserved.	**4**
Addresses Community Need(s)	Our RHP's community needs summary identifies a lack of mental health services as well as the lack of primary care providers in our service area. This project seeks to get adults receiving mental health services in to needed medical treatment when there is a health risk present. The peers will be the tool used to make this connect and to provide encouragement and support.	**4**
Project Scope/Size	The target populations of this project are the adults receiving mental health services from Central Plains Center. The peers will be an integral part of our psychiatric clinic working closely with medical staff to identify consumers who would benefit from medical services to treat unidentified health risks. This project will affect individuals residing in our nine-county service area. In a given year, we serve over 1000 adults. This project will also work closely with our integration project in reaching out to the medical community to build relationships that will facilitate referrals and treatment for our consumers. We will provide interventions that will potentially prevent inpatient treatment episodes and emergency room usage.	**3**
Project Investment	This project will require more human resources than the other project because of the type of project. The project is setup to hire and train individuals to become Peer Specialist. Our overall focus will be on Peer to patient contact. We think at this time very little will be needed in equipment or maintenance to support this project. Meeting the time line in implementing this project should be relative simple because of the organization, legal, professional and staff support that is available. During this time we will be evaluating the risk assessment over the years and make adjustment as identified.	**3**

127374005.2.2	2.18.1	2.18.1.a-i	Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders
Central Plains Center			**127374005**

Related Category 3 Outcome Measure(s):TBD	**127374005.3.2**	**TBD**	**TBD**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-1. Milestone: Train administrators and key clinicians (e.g. PCP, BH clinicians) on: • Understanding what recovery/wellness is and that it is possible • Understanding the value of peer specialists and peer support workers • Understanding how to integrate and support peer workers in their organizations P-1.1. Metric: Number of staff trained P-1.2. Metric: Positive participant evaluations of training a. Data Source: Training records and training evaluation records Goal: To train administrative staff for the organization including six in our executive management team, two mental health directors, five licensed staff and three mental health program coordinators. Estimated Milestone 1 Incentive Payment: $197,111 P-3. Milestone: Identify and train	P-4 Milestone: Select and implement a health risk assessment (HRA) tool. P-4.1. Metric: Number of HRAs completed by consumers. a. Data Source: Internal data base *Goal: Selection of the HRA and providing assessment to 200 mental health patients in our psychiatric clinic with a 20% increase in the next DY.* Estimated Milestone 3 Incentive Payment: $205,629 P-6. Milestone: Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors. P-6.1. Metric: Number of participants receiving peer services. P-6.2. Metric: Number and quality of person centered wellness plans. a. Data Source: Internal records and	I-17. Milestone: Receipt of Recommended Preventative Services I-17.1. Metric: The percentage of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force. 1. Numerator: The number of people receiving services as recommended by the US Preventative Services Task Force 2. Denominator: Individuals aged 18 years and older who receive peer support services. Data Source: Clinical Records Goal: Our goal is to have 15% of the participants receiving recommended services. *Estimated Milestone 5 Incentive Payment:* *$439,952*	I-17. Milestone: Receipt of Recommended Preventative Services I-17.1. Metric: The percentage of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force. 1. Numerator: The number of people receiving services as recommended by the US Preventative Services Task Force 2. Denominator: Individuals aged 18 years and older who receive peer support services. Data Source: Clinical Records Goal: Our goal is to have 30% of the participants receiving recommended services. Estimated Milestone 6 Incentive Payment: $425,074

127374005.2.2	2.18.1	2.18.1.a-i	Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders	
Central Plains Center				**127374005**
Related Category 3 Outcome Measure(s):TBD	**127374005.3.2**	**TBD**	**TBD**	
peer specialists to conduct whole health classes. P-3.1. Metric: Number of peers trained in whole health planning a. Data Source: Training records Goal: To hire peers and to produce documentation of training Estimated Milestone 2 Incentive Payment: $197,111	clinical records Goal: implement peer services and provide wellness planning to 75 MH consumers in this DY with a 20% increase in DY4. Estimated Milestone 4 Incentive Payment: $205,630			
DY 2 Estimated Milestone Bundle Amount: $394,222	DY 3 Estimated Milestone Bundle Amount: $411,259	DY4 Estimated Milestone Bundle Amount: $439,952	*DY5 Estimated Milestone Bundle Amount: $425,074*	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,670,507				

Project Option: 2.1.3 **Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative**
Performing Provider: Childress Regional Medical Center- 133250406
Unique Identification Number: 133250406.2.1
Project Components: 2.1.3.a-f

Provider:	Childress Regional Medical Center is a 39-bed hospital located in the city of Childress, Texas. The hospital is the primary healthcare provider for 30,000 residents in a 5 county area of the southeastern Texas panhandle; all 5 counties are HPSA designated.
Interventions:	This project will introduce and implement the concept of a medical home for area patients. Our goal is to improve community health by encouraging patients to choose a primary care provider and to seek routine, preventative care in a clinic setting.
Need for the Project:	75% of ER encounters are non-urgent. Patients cite obstacles to routine, preventative care including lack of insurance, no other means of payment and inability to get an appointment during clinic hours. Patients with chronic conditions often wait too long to seek care and are hospitalized.
Target Population:	ER patients with the primary diagnosis of CHF(congestive heart failure). In the past 12 months 8% of ER CHF patients were Medicaid and another 10% were indigent. Over the 4 year project period, this project will target >50 patients. A majority of area patients are Medicare or Medicaid eligible or indigent; we anticipate these patients will benefit most from this project. We hope to serve roughly 20 patients per year who meet these specific criteria, but make medical home assignments for as many as 5,000 area patients over the life of the project.
Category 1 or 2 Expected Patient Benefits:	Improved overall health status of Medicaid eligible and indigent patients. By identifying high-risk patients that present to ER as the entry point into the healthcare system and guiding them to the appropriate point of entry and helping the establish a relationship with a primary care provider, we anticipate reducing non-urgent ER encounters to under 50%.
Category 3 Outcomes:	Current hospital CHF readmission rate is 26.1%. By better coordinating care for this chronic condition, we expect to reduce that readmission rate to less than 5%.

Project Option: 2.1.3 **Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative**
Performing Provider: Childress Regional Medical Center- 133250406
Unique Identification Number: 133250406.2.1
Project Components: 2.1.3.A-F

- **Project Description:** The Childress medical community provides good primary care, but we still have non-urgent ER utilization and patients without a team of medical professionals to guide their care. The local clinic has not adopted the principles of medical home, but understands the opportunity.
  Our collaboration with Crosbyton was the result of a good relationship and realization that a minimal allocation in the first pass (~$300k) would not be enough to support a meaningful or sustainable project. The hospital in Crosbyton wanted to partner with another rural hospital and improve the funding opportunity for our facility, so we developed an agreement. Because the funding amount was so small, we didn't dedicate it to a single project, but rather added it into our total allocation ($1.9m). Both of our pass 1 projects (medical home and urgent medical advice) have potential to have a transformative to the patients in our area. We hope to help patients access our system appropriately, drive down non-urgent ER use and get patients in a primary care setting that does a better job of caring for their chronic conditions. Our collaboration with Crosbyton, although relatively immaterial, is certainly helpful.

  - **Goal:** We want to improve community health, rely less on care delivered in the ED, avoid hospitalizations, and provide a better overall experience while driving down costs.
  - **Challenges:** We foresee challenges related to reluctance from established local physicians (this is a new way of doing things), staff training, and patient education. We will address those changes by clearly communicating the opportunity and benefits to physicians, nurses and patients.
  - **Relationship to Regional Goals:** This project supports a critical regional need (CN.1): Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
  - **Expected Outcome:** Over 5 years, we would expect to have a fully functioning patient centered medical home in our hospital-based rural health clinic. This project supports the regional goal of reducing non-urgent ED utilization. The estimated patient impact of this project is zero in DY2 (planning year), 300 in DY3, 750 in DY4, and 1,000 in DY5.
  - **Target Population:** Target population for this project will be patients treated in our ER with primary diagnosis of CHF. We hope to serve roughly 20 patients per year who meet these specific criteria, but make medical home assignments for as many as 5,000 area patients over the life of the project.

- **Starting Point/Baseline:** No local primary care clinic has embraced medical home model to date (0% adoption in February 2013).

- **Rationale:** We selected this project option because we see a real opportunity to revolutionize care in our community. We are aware of alarming rural ED utilization trends (Rural Relevance study by Ivantage in June 2012 showed patient acuity in rural emergency department is relatively low - over 50% of visits are low acuity - compared to published national benchmarks for all emergency departments - 34% of visits are low acuity). The medical home model is a new initiative for our medical community and gives us a tool to counter the prevailing trend.
    - **Project components:** This project will cover core components including:
        - Empanelment: (a) we will assign all patients to one of 8 current local family practice physicians within the only local clinic (Fox Rural Health Clinic). We will be sensitive to patient load and practice supply and demand when making empanelment assignments. This component is included in milestones 4 and 5 of our project.
        - Staffing Restructure: (b)we will consider all clinic employees' skills and credentials and make assignments with the goal of utilizing everyone at the top of their license.
        - Creating links between patients and providers: (c) We will work to create a clinic environment where patients and providers view themselves as partners in care.
        - Expanded Access: (d & e) It doesn't do a patient any good to be assigned to a physician if they can't get scheduled when they need it, so we'll work to make sure they can see their provider or someone within their care team whenever possible. We will also develop our clinic's patient portal so that patients have 24/7 web-based access to their records, appointments, prescriptions, etc…
        - Quality Improvement: (f) We aren't rapid cycle improvement experts, but we plan to learn and implement this approach to quality improvement.
    - **Milestones and Metrics:** we have chosen milestones and metrics that will allow us to effectively establish a medical home that will endure for Childress patients. We will set criteria for selection and assignment in the early years (process milestones), then focus on patient assignment to medical home in later years (improvement milestone)
    - **Regional Need:** this project addresses a critical community need (CN.2 - inability to get an appointment, lack of insurance, need to use ERs for initial contact. There are no projects with related funding from U.S. Department of Health and Human Services. Local data shows that 94% of YTD 2012 ER visits are non-urgent.

- **Related Category 3 Outcome Measure(s):):** IT 6.1 – Patient's involvement in shared decision making was selected as the related category 3 measure.
    - Medical homes have shown to improve patient satisfaction by involving them in care

- Creating links between patients and providers will lead to better health outcomes
- Improved access to care will have a positive impact on patient experience and satisfaction
- Low-income populations are disproportionately affected by poor utilization patterns and uncoordinated care.
- Preventable readmissions cost our region and our healthcare system billions of dollars every year. This project aims to reduce cost for our area.

- **Relationship to other Projects:** Healthcare delivery innovation projects are symbiotic. Medical homes (2.1) and Urgent Care Advice (1.6) will drive down non-urgent ED visits. Primary Care Capacity (1.1) building will improve access and support the medical home access philosophy. And providing appropriate care in the appropriate setting will result in fewer readmissions, fewer HAC's and less overall healthcare spend.
- **Relationship to Other Performing Providers' Projects in the RHP:** There are several other hospitals planning to implement medical homes within our region. We can certainly borrow from their experience, and share our lessons learned, to make everyones project better.
- **Plan for Learning Collaborative:** If a peer regional provider were to take on a similar project, we would suspect a monthly conference call and annual face to face meetings would allow us to share successes and failures. Our RHP anchor has also developed an online forum tool that could be utilized to share developments in real time. Together, we could troubleshoot and develop best practices.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	Medical Home epitomizes patient centered care. We will put high-risk patients, who are often shuffled from one ER or clinic provider to another, in a setting where chronic conditions can be addressed effectively. Many of these patients, particularly in our community, are unfunded or Medicaid patients. The medical home philosophy promises better care at a lower cost. Rural relevance and "hotspotting" studies show the potential impact of a medical home.	**5**
Addresses Community Need(s)	We aren't proposing many projects, but medical home is our primary, because we believe it holds the greatest promise to "move the dial". Our community, particularly those with little or no insurance, need better coordinated care. We see a prominent percentage of non-urgent ER visits. Those patients could be better served in a primary care setting using the medical home philosophy.	**5**
Project Scope/Size	Relative to our other proposed projects, medical home is the biggest. It is our primary project. We will focus on this effort to improve local care because it could result in better quality while saving the system literally millions of dollars in avoidable care (non-urgent ER care, care for chronic conditions, etc…).	**5**

Project Investment	Our medical home project will require significant resources in terms of time and effort. We are a small rural hospital, so even if the dollars are small in relative terms, it is significant for us. But we are committed to doing a good job of implementation. We'll do a good job of getting the ball rolling on this project, and building a sustainable medical home project for Childress patients who can benefit from better care coordination.	**4**

133250406.2.1	2.1.3	2.1.3.a-f	**Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative**
Childress Regional Medical Center			**133250406**
Related Category 3 Outcome	**IT-6.1**	**133250406.3.2**	**Percent Improvement over Patient Satisfaction Scores**

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Process: Implement the medical home model in the only local primary care clinic **Metric(s): P-1.1** Increase # of primary care clinics using medical home model (from zero to 1) **Baseline:** 0% (2/13) **Goal:** 100% **Data Source:** Hospital/Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $112,251 **Milestone 2: P-6** Process: Establish criteria for medical home assignment. **Metric 1: P-6.1** Medical home assignment criteria **Baseline:** No Criteria/**Goal:** Effective Criteria **Data Source:** Hospital/Clinic Criteria **Milestone 2 Estimated Incentive Payment:** $112,251	**Process Milestone 3 [P-2]:** Process: Put in place policies and systems to enhance patient access to the medical home. **Metric(s): P-2.1** Metric 1: Hospital policies on medical home **Baseline/Goal:** Baseline: No Policy (2/13) Goal: Working Policies **Data Source:** Hospital/Clinic Policy **Milestone 3 Estimated Incentive Payment:** $260,227	**Milestone 4: [I-12]:** Improvement: Based on criteria, improve the number of eligible patients that are assigned to a medical home. **Metric(s): I-12.1** Metric 1: Percent of eligible patients assigned to medical home **Baseline/Goal:** Baseline: 0 patients assigned (2/13) Goal: 25% of eligible patients assigned to medical home. Quantifiable patient impact ~750 people. **Data Source:** Hospital/Clinic E H R **Milestone 4 Estimated Incentive Payment:** $262,917	**Milestone 5: [I-12]:** Improvement: Based on criteria, improve the number of eligible patients that are assigned to a medical home. **Metric(s): I-12.1** Metric 1: Percent of eligible patients assigned to medical home **Baseline/Goal: [insert a data point if applicable]** Baseline: 0 patients assigned (2/13) Goal: 50% of eligible patients assigned to medical home Quantifiable patient impact ~1,000 people. **Data Source:** Hospital/Clinic E H R **Milestone 5 Estimated Incentive Payment:** $225,261
DY 2 Estimated Milestone Bundle Amount: **$224,502**	DY 3 Estimated Milestone Bundle Amount: **$260,227**	DY4 Estimated Milestone Bundle Amount: **$262,917**	DY5 Estimated Milestone Bundle Amount: **$225,261**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: **$972,907**			

Project Option: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider: Childress Regional Medical Center- 133250406
Unique Identification Number: 133250406.2.3 – "PASS 3b"
Project Components: 2.10.1.a-d

Provider:	Childress Regional Medical Center is a 39-bed hospital located in the city of Childress, Texas. The hospital is the primary healthcare provider for 30,000 residents in a 5 county area of the southeastern Texas panhandle; all 5 counties are HPSA designated.
Interventions:	This project will introduce and implement the concept of palliative care for patients nearing end-of-life. The project will address patients' desires regarding their treatment and provide informative resources to assist the patient and family members when making choices regarding end-of-life care. Palliative care addresses the entire being-mental, emotional, socioeconomic, culture, and spiritual-not just the physical aspect of living.
Need for the Project:	There are no palliative care programs in the Childress area even though15% of the population is older than 65. Our baseline is no service availability.
Target Population:	Patients undergoing treatment for terminal illness, patients being treated for chronic conditions in poor control and patients whose quality of life has deteriorated due to illness. CRMC's hospice program serves 3 counties and averages a census of 20. And CRMC is the indigent provider for those counties, but since Medicare and Medicaid don't currently cover palliative care services, we expect ~75% of our patients to be unfunded. We hope to serve ~500 patients and families over the 4 year term of the waiver. Once the program is established, we hope to provide about 1,500 palliative care visits in DY4 and 2,000 palliative care visits in DY5.
Category 1 or 2 Expected Patient Benefits:	Improved satisfaction with care and treatment options, pain control and quality time with family and other loved ones…particularly patients who battle cancer. Decreased expense to secure treatment aimed at cure. Patient maintains self-dignity and comfort knowing that palliative care can be provided in the home and not in an institution.
Category 3 Outcomes:	Reduced number of ER encounters for patients in the final days of their lives.

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Performing Provider: Childress Regional Medical Center- 133250406
Unique Identification Number: 133250406.2.3 – "PASS 3b"
Project Components: 2.10.1.a-d

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Project Option: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider: Childress Regional Medical Center- 133250406
Unique Identification Number: 133250406.2.3 –"PASS 3b"
Project Components: 2.10.1.a-d

Project Description: Palliative care is defined as, "an approach that improves the quality of life of patients and their families, facing the problems associated with life-threatening illness, through the prevention and relief from suffering, by means of early identification, impeccable assessment, treatment of pain, and other problems physical, psychosocial, and spiritual." (Sepulvedo et al., 2002; World Health Organization, 2002). We aim to initiate a palliative care program, which to date has been an unmet patient need, in Childress County. We will establish an interdisciplinary care team that will provide medical care as well as advanced symptom management services. As outcome goals shift from cure at any cost to relief and prevention of suffering, palliative care services provide real value to patients and the healthcare system.

Palliative care has been shown to be cost efficient and result in high patient and family satisfaction. The needs of these patients are often very complex and a team of professionals, each expert in their own area is key to successful interventions. We aim to initiate palliative care services that improve patient outcomes and quality of life.

The palliative care team will have several members. Physicians bring expert skills in management of pain and other symptoms for patients as the end of life nears. They can help families navigate decision making with regard to appropriate goals of care based on the individual prognosis for each patient. Nurses are the health care providers who spend more time with patients and their families than any other member of the health care team. They will be the team members who carry out physician orders for care, but also identify and deal with therapeutic issues, and help the patient family maintain a realistic perspective. Our social worker and chaplains will also be available to provide social and spiritual support, because better information leads to better decisions. This process is expected to educate patients about their individual prognosis and potentially assist in transitions to Hospice programs where appropriate.

In order to identify patients who are nearing the end of life, a screening process will be conducted for local patients who are receiving cancer treatment. These often critically ill patients may meet the criteria for palliative care intervention.Our home health service will trend this data and screen other groups as indicated. Another area of potential screening is the emergency room and as the program grows this group will be targeted for screening as well. Our target population is all patients who fall into either of those two groups: patients receiving cancer treatment, and ER patients who might benefit from the program.

- **Goal:** The goal of our palliative care program is to catch area patients that currently fall through the cracks because they aren't homebound (home health criteria) and they aren't terminal (hospice criteria). We believe we can provide a better quality of life to these patients while saving the system money spent on acute care and readmissions. Over the next 5 years, we hope to provide more than 10,000 palliative care visits to area patients in need.

- **Relationship to Regional Goals:** Our region's primary goals are to make progress on identified community needs and to achieve progress towards the triple aim goals of improving the patient experience including quality and satisfaction, improving the health of populations and reducing the per capita cost of care. This project will contribute towards improving the quality and satisfaction of the patient by proving the right approach to care in a timelier manner. Studies have shown that palliative care services improve patients' symptoms, allow patients to avoid hospitalization and to remain safely and adequately cared for at home, lead to better patient and family satisfaction, and significantly reduced prolonged grief and posttraumatic stress disorder among bereaved family members.
- **Challenges:** The most difficult challenge to implementation of an effective palliative care program might simply be getting a new program started. We also worry about acceptance from treating physicians and family members. The historical perception of palliative care (and eventual hospice care) is that it is an admission of failure by the physician and the family perceives that there is no hope left for the patient. Perceptions are changing as physicians and families see and experience the benefits of palliative care. This project will move the palliative care approach forward by incorporating physician education about the benefits of the palliative care approach. Further, patients and families will receive education and guidance on the benefits of palliative care in the treatment of the patient.
- **Five Year Expected Outcome:** Over the life of the project, we hope to develop a self-sustaining palliative care program for the patients of Childress County. A program that not only focuses on terminal cancer, but provides end-of life care for a number of other conditions, such as congestive heart failure, other circulatory conditions, COPD, and dementia. And we believe the program will gain acceptance as patients and families experience the benefits. All of this results in better care while saving the system money in futile curative care costs at the end of life.

Starting Point/Baseline: This is simple, since we have never offered the service. FY20120 patients enrolled…no palliative care team or program. Our baseline is zero…no service, zero patients served.

Rationale: Most adults prefer to be cared for at home if terminally ill and the majority would be interested in a comprehensive program of end of life care, such as hospice. Although most Americans would prefer to die in their home, most die in institutions. Approximately 50% of DNR's are written within two days of death. Often, a patient's preference to forego resuscitation is unknown or disregarded (Middlewood et al., 2001). The Journal of the American Medical Association (19:281(2);163-168) identified patients in palliative care programs need the following: pain and symptom control, no inappropriate prolongation of the dying process, a sense of control, less burdens for the family, and a strong relationship with family. A CRMC palliative care program can support the complex needs of the patient and their caregivers in a clinical setting.
It has been demonstrated that palliative care teams in hospitals improve multiple outcomes including both clinical and financial. Patient illness/dying trajectories often result in slow decline, periodic crises, and death (e.g. congestive heart failure). These are the

most frequently readmitted patients who represent significant savings potential if our systems of care can be transformed. There is emerging literature that shows palliative care teams improve patient and family satisfaction with care at the end of life. Specifically, palliative care teams can assist with pain and symptom management, recognition of the patient as a whole person, clear medical decision-making, life completion and preparation for death. Palliative care consultations have been clearly associated with decreased costs of care at the end of life and higher quality of life in the week before death. Palliative care teams are instrumental in assisting with transitions in care such as moving from cancer treatment to comfort care. Conversations about preferences for end-of-life care have been shown to improve quality of life for patients and caregiver bereavement. Additionally, palliative care can and should be provided to any patient with suffering, regardless of their prognosis or options for life-prolonging treatments.
The primary goal of this project is to enhance end of life care for Childress patients to better accommodate the needs of the patient population, families, and community. Patients should receive dignified and culturally appropriate care to relieve suffering in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences. CRMC sees a disproportionately large number of patients who are under- or uninsured, non-English speaking, or of lower socioeconomic status, who often present with more advanced illness and have fewer treatment options. For these reasons, we see a large number of patients with a high symptom burden and poor prognosis.

Project Components:

- Project planning (core component a) is where we start. We will develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program.
- Through the use of goals of care discussions with patients and families the palliative care team will discuss prognosis and options for care that helps to transition patients (core component b) from acute hospital care into home care, hospice or a skilled nursing facility. The key element of a goal of care discussion is to make sure the patient/ family understand the severity of illness, the prognosis, and be presented with alternative to high intensity care that may not be wanted or needed. The interdisciplinary team includes a social worker that will help to facilitate these arrangements.
- In order to continually improve, the team will implement a patient/family experience survey (core component c) regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care. These surveys will be sent to every patient/family who receive care from the team. Results will be reviewed quarterly to improve the function of the team. Results will be shared with each member of the team and after initial benchmarking we will use a programmatic approach to drive performance higher.
- As the program develops there will be a need to continually improve the program. To accomplish this, the group will conduct on-going quality improvement (core component d) using methods such as rapid cycle improvement. In this process a measure is selected and the data analyzed. An aim statement is formulated to drive the improvement and a plan devised to improve the given metric.

Unique community need identification numbers the project addresses:

- CN.3 -Poor insurance support or uninsured
- CN.5 - Need for providers to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease and other chronic conditions. Travel to Urban areas for care is difficult.

Related Category 3 Outcome Measure(s):IT-13.3 Proportion of patients with more than one emergency room visit in the last days of life (NQF 0211)- Percentage of patients who died from cancer with more than one emergency room visit in the last days of life. 285 ***(****Standalone measure)*

This measure was selected because patients at the end of life often seek care in the emergency room setting. Such care is often very expensive. The care in many cases could be provided in the home through hospice at much less cost and with better patient/family satisfaction. A palliative care program intervention holds promise to improve this rate very effectively and achieve the triple aim goals well.

Relationship to other Projects: This project supports the reduction in unnecessary admissions and readmissions. By providing more patient centered care with transition to involvement of hospice the patients receive the appropriate palliative care at home instead of undergoing a costly admission. Patient satisfaction is enhanced because patients do not undergo uncomfortable admissions and can stay within their own home while receiving high quality care. This program ties to the following projects:

- 133250406.2.1 – Enhance/Expand Medical Home

Relationship to Other Performing Providers' Projects in the RHP: Both UMC and Covenant Health System in Lubbock have proposed an expansion to their palliative care programs. While these projects are similar, they focus on separate populations, and they aren't startups like ours.

Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This palliative care intervention greatly helps to further the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. Most patients prefer to die at home however most patients die in the hospital because they did not have access to high quality palliative care programs. This project will serve the Medicaid and uninsured residents of our county Numerous studies have shown that Palliative care will Improve outcomes while containing cost growth by reducing unnecessary admissions and readmissions.	**4**
Addresses Communit y Need(s)	Palliative care is an unmet community need. Currently there is no local access to high quality palliative care. Within our county, hospital patients who have Medicaid or are underinsured are frequently faced with critical illness or end of life issues. As this facility serves as the safety net hospital for the area it is critical that high quality palliative care programs exist to meet this need.	**4**
Project Scope/Size	The scope of our palliative care program will be moderate. We're a small community, but we know there are patients who fall through the cracks of coordinated care programs. In the end, everyone faces death and it is critical that patients receive high quality end of life care. This is true regardless of the economic class or ethnic background. It is critical that each person's end of life care is centered on their unique needs. In this way the various cultures and ethnic groups can receive culturally appropriate care at such an important time as critical illness and end of life.	**3**
Project Investment	The major capital needed to deliver high quality care is the time of the professionals who will be working with the patients and their families to deliver this care. As might be expected this can be considerable as families grapple with the very difficult decisions regarding their loved ones. Palliative medicine is a multi-disciplinary field and practitioners from across medicine will have to be engaged. From social workers to chaplains to nurse managers to physicians all are integral to an effective team	**3**

133250406.2.3 –"PASS 3b"	***2.10.1***	***2.10.1.A-D***	**Implement a Palliative Care Program to address patients with end-of-life decisions and care needs**
Childress Regional Medical Center			*133250406*
Related Category 3 Outcome Measure(s):	*13350406.3.4*	*IT-13.3*	IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: [P-1]: Process - Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program. Metric 1 P-1.1: Business Case Baseline/Goal: Baseline: no report Goal: Complete report Data Source: documentation of planning activities Milestone 1 Estimated Incentive Payment *(maximum amount):* $474,151	**Milestone 2** [P-2]: Process – Educate primary care specialties in providing palliative care including non-cancer training. Metric 1 [P-2.1]: Primary care training and education in palliative care Baseline/Goal: Baseline: none trained Goal: 50% of local FP's trained Data Source: Tracking database Milestone 2 Estimated Incentive Payment: $526,130	**Milestone 3** [P-5]: Process – Implement/expand a palliative care program Metric 1 [P-5.1]: Goal: Implement comprehensive palliative care program Data Source: Palliative care program Milestone 3 Estimated Incentive Payment: $252,928.50 **Milestone 4** [I-10]: Improvement – Among patients who died in the hospital, increase the proportion who received a palliative care consult Metric 1 [I-10.1]: % of total in-house deaths who had a palliative care consult Goal: 20% (15 hospital patients receive consult, 1,500 total palliative care visits) Data Source: EHR Milestone 4 Estimated Incentive Payment: $252,928.50	**Milestone 5** [I-10]: Improvement – Among patients who died in the hospital, increase the proportion who received a palliative care consult Metric 1 [I-10.1]: % of total in-house deaths who had a palliative care consult Goal: 30% (20 hospital patients receive consult, 2,000 total palliative care visits) Data Source: EHR Milestone 5 Estimated Incentive Payment: $416,689
Year 2 Estimated Milestone Bundle Amount*:* $474,151	Year 3 Estimated Milestone Bundle Amount: $526,130	Year 4 Estimated Milestone Bundle Amount: $505,857	Year 5 Estimated Milestone Bundle Amount: $416,689
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,922,828			

Project Option: 2.7.6 "Other" project option: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner not described in the project options above.
Performing Provider: City of Amarillo/Pending
Unique Identification Number: Pending.2.1
Project Components: 2.7.6.a-e

- **Provider:** The City of Amarillo Department of Public Health is the agency tasked with performing the essential public health functions on behalf of the Amarillo Bi-City-County Health District. The Amarillo DPH jurisdiction includes Potter and Randall Counties. The Amarillo DPH's role is to monitor health, investigate problems/hazards, inform, educate, mobilize partnerships, develop health policy, enforce laws, link community members to services, and evaluate effectiveness and research solutions for health issues.

- **Interventions:** Program elements included from RHP Planning Protocol 2.7.6, Milestone P-X1.1-3 are: development of an Immunization Program for low income adults 19 years and older, purchase vaccine to immunize targeted adult population ages 19 and older who are uninsured or underinsured, employ staff members to provide adult vaccines, and purchase mobile clinic vehicle to operationalize outreach for adult safety-net vaccination events.

- **Need for the project:** The benefits to patients from this particular project relate the milestones and outcome measures consisting of increasing baseline percentage of adult low income clinic clients vaccinated over time and reducing admission rates among low income adult clinic clients for vaccine preventable diseases such as bacterial pneumonia and influenza over time. This program directly relates to Community Need #11 relating to inadequate vaccination rates in adults. Also of note: this is the only RHP 12 project addressing this need.

- **Target Population:** This project proposes to target low-to-no income adult Amarillo/Potter/Randall clients with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization.

- **Category 2 expected benefits:** During the project period, it is expected that over 4,500 individuals will be vaccinated.

- **Category 3 outcomes:** IT-2.10, "Flu and pneumonia Admission Rate," will be used as the project outcome measure with a DY4 increase in immunization rates by 5% over baseline and DY5 increase of 10% over baseline.

Project Option: 2.7.6 "Other" project option: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner not described in the project options above.
Performing Provider: City of Amarillo/Pending
Unique Identification Number: Pending.2.1
Project Components: 2.7.6.a-e
Project Description:
Every year vaccine preventable diseases in adults account for millions of dollars in health care expenditures. Between 2005 and 2010, there were 1,987 hospital admissions in Potter County for bacterial pneumonia. The cumulative cost of just these hospital admissions was over $54 million dollars (inflation adjusted for 2013). Between 2005 and 2010, there were 1,574 hospital admissions in Randall County for bacterial pneumonia. The cost for Randall County was $44 million dollars (again, inflation adjusted for 2013). Pneumonia vaccine can prevent a hospitalization cost of over $28,000 per case. Expanded use of adult immunizations, particularly pneumonia, can prevent disease and substantially reduce health care costs.
In previous years, the Texas Department of State Health Services provided many adult vaccines to local health departments, including bacterial pneumonia and influenza. Legislative funding cuts from a year ago have eliminated the provision of adult vaccines to local health departments for an adult safety-net program. The vaccination of adults, like the vaccination of children, produces predictable outcomes that are well documented. Increased vaccination results in increased levels of immunity and reduced morbidity and mortality. A clearly associated secondary outcome is reduced health care expenditures—in the greater Amarillo area, up to $98 million dollars over 5 years.
This project proposes to target low-to-no income adult Amarillo/Potter/Randall clients with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization. The specific vaccines to be administered include: meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella. Provision of these vaccines, especially to the low income families of Potter and Randall Counties, is a highly cost effective proposition. The ability for us to provide these vaccines to individuals who would not otherwise receive them is central to the mission of public health. In the process, thousands of dollars in health care expenditures can be avoided.
This project plans to create an adult immunization program to include an additional nurse, clerk, medical supplies, and vaccine. The majority of the vaccines will be administered at the Department of Public Health in Amarillo, with additional services being provided from a mobile clinic platform. These mobile clinics will be targeted to meet special community needs. During the project period, it is expected that over 15,000 individuals will be vaccinated. No other federal dollars or support will be used for this project.

2.7.6 "Other Projects" Option: Amarillo Health Department Adult-Safety Net Immunization Program

a) *Design and implement Immunization teams to administer vaccines to target populations.*
b) *Ensure that target population can access immunization center teams in person or by phone or email.*

c) *Increase target population participation through education, community alliances, contact with area providers, announcements, and community events, and access to mobile clinics.*
d) *Implement projects to generate target population awareness of the necessity to be vaccinated.*
e) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project ot a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.*

Goal

The goal of this project is to target low-or-no income Potter and Randall County adults with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization. The specific vaccines to be administered include: meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella. Provision of these vaccines, especially to the low income families of Potter and Randall Counties is a highly cost effective proposition. This project will create an adult immunization program, establish outreach with mobile clinics, and increase awareness to maximize voluntary immunizations among low income populations in Potter and Randall Counties. The most immediate goal of the project is to administer 15,000 doses of vaccines per year to these adults. In doing so, cases of disease will be prevented. Hospitalizations will be avoided; and substantial savings in health care expenditures will be realized.

Challenges/Issues

Motivating individuals to obtain preventive vaccines is the major challenge. Preventive strategies are not traditionally embraced by low income populations. Marketing these preventive services to low income families will be a substantial challenge. The ability to integrate vaccine administration with other health visits may provide a helpful approach. Providing vaccines at a very low cost should also increase utilization.

Expected Outcome/5-year Outcome

The outcome of this project is to increase the proportion of low income Potter and Randall County adults with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization, thereby, reducing hospitalizations for the combined flu and pneumonia rates among this population. This DSRIP goal is to reduce overall hospitalizations for the combined flu and pneumonia rates by 5% overall by year 5. This outcome will demonstrate the ability to focus services on a particular at risk population and bring about improved health outcomes within a few short years. The cost effectiveness of vaccines is well documented. The ability to expand the model to adults and demonstrate reductions in hospitalization rates in areas such as bacterial pneumonia and influenza can be particularly helpful in formulating health policy.

Interrelated Projects (Regional Goals)

RHP 12 performed an in-depth, comprehensive community needs assessment that included several sources of primary data, secondary data and key informant information. This assessment collated several documents and prioritized community needs based on priority as well as 1115 waiver goals.

Starting Point/Baseline

Establish and implement immunization program for adults. At present, no baseline exists; however, as the project begins to serve clients, immunity levels will be recorded for the various vaccine categories so that comparisons can be made in subsequent years.

Rationale

This program directly relates to **Community Need #11** relating to inadequate vaccination rates in adults. Also of note: this is the only RHP 12 project addressing this need. Immunization or vaccination is a large success story in existing programs in Texas and in public health. An organization called Healthy People sets national goals every ten years for the improvement of health in America. The organization has a 2020 goal for increasing vaccinations of multiple diseases such as meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, measles, mumps, and rubella (Healthy people 2020 objectives, 2012). The vaccination of children by routine immunization schedules saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by $9.9 billion, and saves $33.4 billion in indirect costs according to the Healthy People organization. The vaccination success story has not eliminated these diseases because there are over 30,000 deaths and 400,000 cases of illness in the United States that could be prevented with community programs according to the CDC. The CDC has a Guide to Community Preventive services that have three categories of interventions for increasing vaccination in a community, which are increasing community demand for vaccination, enhancing access to vaccination services, and provider-based interventions. The community demand can be increased by reminding clients on vaccinations through calls, email or regular mail, requiring vaccination in daycare, schools and college attendance, and community education. The access to vaccination services can increase by reducing out-of-pocket costs for vaccinations, expanding access to vaccinations in health care facilities, and more vaccination opportunities in non-medical settings. The provider can increase vaccination by reminding patients on vaccinations during provider visits, standing orders for vaccination by providers and increased provider education on vaccines (Reviews of Evidence Regarding Interventions to Improve Vaccination Coverage in Children, Adolescents, and Adults, 2000).[25][26][27]

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[25] Ndiaye SM, Hopkins DP, Shefer AM, Hinman AR, Briss PA, Rodewald LE, Willis B, Task Force on Community Preventive Services. Interventions to improve influenza, pneumococcal polysaccharide, and hepatitis B vaccinations coverage among high-risk adults: a systematic review. American Journal of Prevention Medicine. 2005. Vol 28 No 5S, pp 248-279.

[26] Briss PA, Rodewald LE, Hinman AR, Shefer AM, Strikas RA, Bernier RR, Carandes-Kulis VG, Yusuf HR, Ndiaye SM, Williams SM, Task force on Community Preventive Services. Reviews of evidence regarding interventions to improve vaccination coverage in children, adolescents and adults. American Journal of Prevention Medicine. 2003. Vol 18 No 1S, pp 97-140.

[27] Healthy people 2020 summary of objectives: Immunization and Infectious Diseases. Available at: http://healthypeople.gov/2020/topicsobjectives2020/pdfs/Immunization.pdf. Accessed October 12, 2012

An important vaccination that is used at a national level is for influenza, which has caused 114,000 excess hospitalizations and 36,000 deaths according to the CDC. There is an increase in mortality for patients older than 65 and those that have chronic disease because of complications with influenza. In 2000, the influenza vaccination coverage for adults with high-risk conditions was 33%, which was below the Healthy People 2010 goal of 60% (Interventions to Improve Influenza, Pneumococcal Polysaccharide, and Hepatitis B Vaccination Coverage among High-Risk Adults, 2005). This new community program reinstates the adult safety-net vaccination program that was eliminated in early 2011. The Texas Department of State Health Services discontinued the purchase of vaccine for local health departments based on budget cuts and a newly-interpreted rule from the Centers for Disease Control regarding the use of the Vaccine for Children (VFC) vaccine supply program. Under the new interpretation, underinsured and uninsured adults were no longer covered. The result of this rule change was the discontinuation of low or no-cost immunization programs for adults who needed them most.

Related Category 3 Outcome Measure(s)

IT-2.10, "Flu and pneumonia Admission Rate," will be used as the project outcome measure. This project proposes to target low income Potter and Randall County adults with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization. The specific vaccines to be administered include: meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella. Provision of these vaccines, especially to the low income families of our jurisdiction is a highly cost effective proposition. Families are struggling to put food on the table must postpone a trip to town because gasoline prices are too high are not likely to have disposable income to invest in these vaccines. The costs are prohibitive for low-income families in the traditional healthcare model of service. The ability for our local health department to provide these vaccines to individuals who would not otherwise receive them is central to the mission of the Amarillo Hospital District, the Amarillo Bi-City-County Health District and the Department of Public Health. It is primarily preventive in nature and will help to protect the vaccine recipients, as well as the community. These vaccinations will reduce the burden of disease and, potentially, thousands of dollars in health care expenditures can be avoided.

Relationship to Other Projects in RHP Plan

To our knowledge, this is the only immunization project being submitted. It may be used as an expansion of adult safety-net immunization services for the RHP 12 and Texas Panhandle. Again, this is an enhancement of a former program with DSHS and HHSC in Texas.

Plan for Learning Collaborative

The plan for a learning collaborative system is included in the Milestone and Metric description:

Milestone 2: P-7: Participate in face to face learning meetings or seminars at least twice per year with other providers and the RHP to promote shared or similar projects AND **Metric 1: P-7.1**: Participate in semi-annual face to face meetings organized by the RHP. Organize semiannual meetings to familiarize Potter and Randall County providers with the adult immunization program.

This plan formalizes the way in which the benefits, successes and best practice information is share with other RHP participants. It is important to demonstrate the immunization project as a chief intervention to prevent recurring hospitalizations from vaccine preventable diseases.

Project Valuation

This project is valued to implement cost-savings interventions of immunizations to address the $98 million dollars spent over a 5 year period in bacterial pneumonia infections in Potter and Randall Counties. The average cost of these hospitalizations is $28,110 per admission on average (adjusted to 2013 with inflation). In fact, of the $9.8 million dollar investment, it would only require the prevention of 349 cases of bacterial pneumonia over 5 years to become budget neutral. In addition, each case of bacterial meningitis prevented saves Texas $949,000. In Amarillo, we have had 961 cases of influenza hospitalizations in the previous 3 years. Each influenza admission costs an average of $24,000. This is a $23 million dollar cost to our community over the previous 3 years for influenza alone. An adult case of pertussis costs the health care system $8,900 per case. Subsequent to this analysis, the cost of routine vaccination for these conditions seems to be an obvious intervention with the potential for staggering cost savings over time. While the budget includes vaccine, staffing, medical supplies and a mobile clinic vehicle, it should be a cost-effective program overall. This program anticipates providing over 15,000 immunizations. The valuation is based on scoring for meeting Community Need #11 and this program will utilize the entire Pass 1 allocations based on the potential savings associated with the intervention.

Milestones and Metrics Table

Pending.2.1	2.7.6	2.7.6 a-e	**Title:** "Other" project option: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner not described in the project options above
Performing Provider (PP): City of Amarillo Department of Public Health			**PP TPI: Pending**
Related Category 3 Outcome Measures	**Pending.3.1**	IT-2.10	Bacterial Pneumonia Admission Rate
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: **P-X1**: Development of an Immunization Program for low income adults 19 years and older Metric 1: P-X1.1: Purchase vaccine to immunize targeted adult population ages 19 and older who are uninsured or underinsured Metric 2:P-X1.2: Employ 2 staff members to provide adult vaccines Metric 3: P-X1.3: Purchase mobile clinic vehicle to operationalize outreach for adult safety-net vaccination events Data Source: Program documentation. **Milestone 1 Estimated Incentive Payment (max amount): $2,044,435**	**Milestone 2:** **P-7**: Participate in face to face learning meetings or seminars at least twice per year with other providers and the RHP to promote shared or similar projects Metric 1: P-7.1: Participate in semi-annual face to face meetings organized by the RHP. Organize semiannual meetings to familiarize Potter and Randall County providers with the adult immunization program Baseline/Goal: Baseline is 0. Goal is At least 2 meetings to educate providers and exchange information Data Source: Program documentation **Milestone 3:** **I-5**: Identify number and percentage of low income adult clinic clients who need vaccine. Metric 1: I-5.1 Develop baseline immunity levels among low income adults utilizing community clinics. a) Numerator: Number low income adult clinic clients	**Milestone 4**: I-7: Improve immunity levels among adult low income clinic clients after immunization program implementation Metric 1: I-7.1: Increase baseline percentage of adult low income clinic clients vaccinated overtime. a) Numerator: Number low income adult clinic clients vaccinated. b) Denominator: Total number low income adult clients served by Amarillo Department of Public Health Goal: Increase immunity levels by 10% from DY 3 baseline over time. Baseline: Number and proportion low income adult clinic clients vaccinated. Data Source: Documentation, Health records in community clinics serving low income adults, internal data systems **Milestone 4: Estimated Incentive Payment total of $2,281,590**	**Milestone 5:.** **I-X2**: Reduce admission rate among low income adult clinic clients for vaccine preventable diseases such as bacterial pneumonia and influenza over time. Metric 1: I-X2.1: Admissions for vaccine preventable diseases among low income Potter and Randall County residents a) Numerator: Number admissions among low income adult clinic clients for vaccine preventable diseases. b) Denominator: Total number low income adult clients served by Amarillo Department of Public Health Goal: Demonstrate 5% reduction in admission rate for vaccine preventable diseases among low income adult clinic clients from baseline in DY 3. Data Source: Hospital discharge data, health records, internal data systems **Milestone 4 Estimated Incentive**

Pending.2.1	2.7.6	2.7.6 a-e	**Title:** "Other" project option: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner not described in the project options above	
Performing Provider (PP): City of Amarillo Department of Public Health				**PP TPI: Pending**
Related Category 3 Outcome Measures	**Pending.3.1**		IT-2.10	Bacterial Pneumonia Admission Rate
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	vaccinated. b) Denominator: Total number low income adult clients served by the Amarillo Department of Public Health **Milestone 2 and 3 Estimated Incentive Payment (max amount): $2,132,791**			**Payment (max amount): $2,204,435**
Year 2 Estimated Milestone Bundle Amount: $ 2,044,435	**Year 3 Estimated Milestone Bundle Amount:** $2,132,791		**Year 4 Estimated Milestone Bundle Amount:** $2,281,590	**Year 5 Estimated Milestone Bundle Amount:** $2,204,435
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):				**$8,663,251**

Project Option: 2.7.6 "Other" Project Option: ***2.13.2: "Other" project option: Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above.***
Performing Provider: City of Amarillo Department of Public Health / Pending
RHP Project Identifier: Pending.2.2 – **"PASS 2"**

Provider: Amarillo Recovery from Alcohol and Drugs (ARAD) is a 501 (c) (3) organization committed to providing the equivalent of 30-day residential treatment for addiction to alcohol or drugs to indigent clients in Amarillo and the surrounding area and will be licensed by the State of Texas. The local homeless shelters have agreed to partner with ARAD and provide a drug and alcohol free living environment during the 30-day treatment. Texas Panhandle Centers will provide screening, mental health assessment, treatment, and classroom space for ARAD. ARAD will transport the clients from the homeless shelters six days a week to the treatment program, provide treatment and lunch, and then transport the clients back to shelters. The City of Amarillo Department of Public Health will contract with ARAD for the accomplishment of these services.

Interventions: Program elements included from RHP Planning Protocol 2.13.1, Milestone P-2 are: 30-day treatment services for enrolled patients, transportation to the ARAD program services, psychosocial rehabilitation (program intervention to reduce high-risk behaviors leading to recidivism/relapse), cognitive behavioral therapy (treatment to overcome addiction behaviors), and substance abuse services (this encompasses the majority of ARAD treatment and counseling interventions).

Need for the project: For the first time in Amarillo, "no cost treatment" will be available for homeless individuals addicted to alcohol or drugs. Homeless individuals will transition from life on the streets to residing in a shelter and becoming sober. Criminal justice resources may be redirected from dealing with public nuisance complaints to more serious crime problems. Indigent care costs will decline as these individuals are no longer taken to the hospital for medical clearance prior to arrest, or emergency treatment for illnesses and accidents directly related to homelessness and addiction to alcohol or drugs.

Target Population: Homeless adult men and women addicted to alcohol or drugs in Amarillo or the immediate area. Local homeless shelters will be ARAD's primary source of referrals. ARAD may also receive referrals from specially trained law enforcement officers (Crisis Intervention Team) and behavioral health professionals (Mobile Crisis Outreach Team).

Category 2 expected benefits: ARAD expects to treat 1,000 clients in the next 5 years.

Category 3 outcomes: IT 9.1 is to reduce the admissions to the criminal justice system due to substance abuse issues by 5% in DY4 and 5% in DY5

Project Option: ***2.13.2: "Other" project option: Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above.***
Performing Provider: City of Amarillo Department of Public Health / Pending
RHP Project Identifier: Pending.2.2 – **"PASS 2"**

Project Description:

Amarillo Recovery from Alcohol and Drugs (ARAD) is a 501 (c) (3) organization committed to providing the equivalent of 30-day residential treatment for addiction to alcohol or drugs to indigent clients in Amarillo and the surrounding area. No such service is currently available in Amarillo. ARAD will accomplish this goal by partnering with existing providers in Amarillo to piece together the treatment program without duplicating services. The local homeless shelters have agreed to partner with ARAD and provide a drug and alcohol free living environment during the 30-day treatment. Texas Panhandle Centers (a not for profit behavioral health provider) will provide screening, mental health assessment, mental health treatment, and classroom space for ARAD. Our treatment program will be licensed by the State and provide intensive outpatient treatment for our homeless clients. ARAD will transport the clients from the homeless shelters six days a week to the treatment program, provide treatment and lunch, and then transport the clients back to their shelters at the end of the day.

Program elements included from RHP Planning Protocol 2.13.1, Milestone P-2:

- 30-day treatment services for enrolled patients
- Transportation to the ARAD program services
- Psychosocial Rehabilitation—program intervention to reduce high-risk behaviors leading to recidivism/relapse
- Cognitive Behavioral Therapy—treatment to overcome addiction behaviors
- Substance Abuse Services—this encompasses the majority of ARAD treatment and counseling interventions

Rationale:

The community will have multiple benefits from ARAD's program. For the first time in Amarillo, "no cost treatment" will be available for homeless individuals addicted to alcohol or drugs. Homeless individuals will transition to life on the streets to residing in a shelter, and becoming sober. Amarillo will experience fewer homeless individuals on the street panhandling for money or creating an appearance of decay in the downtown area. Criminal justice resources may be redirected from dealing with public nuisance complaints generated by the homeless individuals (public intoxication, disorderly conduct, etc.) to more serious crime problems. Medical indigent care costs will decline as these individuals are no longer taken to the hospital for medical clearance prior to arrest, or emergency treatment for illnesses and accidents directly related to homelessness and addiction to alcohol or drugs. Amarillo's crime rate will decline slightly as these individuals transition from criminal behavior related to addiction to more socially responsible behavior and employment.

Target Population:
ARAD's target population is homeless adult men and women addicted to alcohol or drugs in Amarillo or the immediate area. We expect that our local homeless shelters will be ARAD's primary source of referrals, although there is interest from emergency department physicians in direct referrals of homeless individuals being treated in a hospital setting who are ready for treatment for his or her addiction to alcohol or drugs. ARAD may also receive referrals from specially trained law enforcement officers (Crisis Intervention Team) and behavioral health professionals (Mobile Crisis Outreach Team) may find appropriate homeless individuals and directed them to the ARAD program.

Our project goals are to reduce the number of homeless individual addicted to alcohol or drugs. In our treatment population, ARAD's goals are to increase the number of days of sobriety of the clients, reduce the number of arrests the clients experience, and reduce the medical costs incurred by the clients.

ARAD's target population will present challenges. Many will have co-occurring mental health issues. This population may be resistant to treatment and recovery. Homeless individuals may be difficult to track after treatment for long-term follow-up studies.
In five years, ARAD expects to treat almost 1,000 individuals. The Amarillo community should detect a noticeable improvement in the quality of life in the downtown area. Indigent care costs should decline as well as demands for police service in the downtown area.

2.13.2 Provide an Intervention for a Targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting: Amarillo Recovery from Alcohol and Drugs (ARAD) Program

- *Design community-based specialized interventions for target populations*

- *Transportation to community-based services*
- *Substance abuse services*

- *Enroll and serve individuals with targeted substance abuse issues*
- *Evaluate and continuously improve the intervention*
- *Participate in face-to-face learning*
- *Lower the criminal justice admission/readmission rates*
- *Track and increase the completion of the ARAD treatment program*

Goal

Our project goals are to reduce the number of homeless individual addicted to alcohol or drugs and to lower the criminal justice admission/readmission rates in the target population. ARAD's goals are to increase the number of days of sobriety of the clients, reduce the number of arrests the clients experience, and reduce the medical costs incurred by the clients.

Challenges/Issues

Several challenges to this program exist. First, the target population of indigent patients with substance abuse behavioral issues are difficult to serve due to inherent compliance challenges. While this project works to enroll indigent individuals into a treatment program, completion rates for the full 30-day intervention will likely be low. However, even a modest success in the 30-day completion should result in fewer admissions/readmissions into the criminal justice system and the hospital setting. Secondly, other barriers exist for completion rates for the program. Transportation has long been recognized as an issue for this target population. As such, this program will provide daily transportation from the shelters to the treatment facility for classes and counseling. Thirdly, the community shelters that host these patients overnight will need to commit to coordination and cooperation for the continued success of the program. The ARAD design does allow for a modest "stay fee" to be paid to the shelters to support those individuals who enroll into the ARAD program.

Expected Outcome

The expected outcome of this project is to increase the numbers of indigent patients with substance abuse problems enrolled into the ARAD program. Related improvement outcomes include reductions in substance abuse in the patients completing the 30-day program, reductions in rates of criminal justice system admissions, reductions in emergency department use due to substance abuse, and fewer expulsions from community shelters due to substance abuse.

Interrelated Projects (Regional Goals)

RHP 12 performed an in-depth, comprehensive community needs assessment that included several sources of primary data, secondary data and key informant information. This assessment collated several documents and prioritized community needs based on priority as well as 1115 waiver goals. This program directly relates to **Community Need #8** relating to **"alcohol abuse and substance abuse."**

Starting Point/Baseline

The starting point for this program is essentially "zero". No 30-day substance abuse treatment program exists in the Amarillo area and this program is specifically targeted to the indigent population. The ARAD program will track enrollees, monitor their progress in the treatment for alcohol and drug abuse, then measure the rate reduction in the criminal justice system.

Related Category 3 Outcome Measure(s)

IT-9.1, "Decrease admissions/readmissions of substance abuse to the criminal justice setting," will be used as the project outcome measure. Criminal justice costs will decline as these individuals are no longer taken to the hospital for medical clearance prior to arrest, or emergency treatment for illnesses and accidents directly related to homelessness and addiction to alcohol or drugs. Amarillo's crime rate will decline slightly as these individuals transition from criminal behavior related to addiction to more socially responsible behavior and employment.

Plan for Learning Collaborative

The plan for a learning collaborative system is included in the Milestone and Metric description: M**ilestone 2: P-7**: Participate in face to face learning meetings or seminars at least twice per year with other providers and the RHP to promote shared or similar projects AND **Metric 1: P-7.1**: Participate in semi-annual face to face meetings organized by the RHP. These experiences will allow other RHP members to benefit from the ARAD successes and best practices.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation

The ARAD model is the only comprehensive, indigent-focused, shelter-centered intervention within RHP 12 to address Community Need #8: Substance Abuse Services. Because of this focus, substantial resources are needed to accomplish the stated goals. In fact, the DSRIP payments are only a portion of the operating cost of this project. Costs include staffing with trained, licensed substance abuse counselors, case managers, clerical staff and administrative costs. The program also includes transportation and shelter support costs. Research shows that there are approximately 942 substance abuse admissions per year in Amarillo. With an average cost of $7,610 per admission, the annual burden to our community and Texas is $7.1 million dollars. With a total support of $1.2 million to ARAD over the 5 year period, even a 10% annual reduction would exceed the cost of the ARAD support

Pending.2.2. – "PASS 2"	2.13.2	**N/A**	***"Other" project option: Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above.***	
Performing Provider (PP): City of Amarillo Department of Public Health				**TPI Pending**
Related Category 3 Outcome Measures	**Pending.3.2**	IT-9.1	Decrease in mental health admissions and readmissions into the criminal justice settings such as jails or prisons	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: **P-2**: **Design a community-based specialized intervention for the target population.** Metric 1: P-2.1: Project plans based on evidence and expertise in substance abuse treatment issues; includes plans for transportation to appointments, substance abuse services, and psychosocial rehabilitation Baseline: No program currently exists Data Source: Program documentation. **Milestone 1 Estimated Incentive Payment $312,789**	**Milestone 2:** **P-3**: **Enroll and serve individuals with targeted substance abuse issues.** Metric 1: P-3.1: Enroll participants Baseline/Goal: Baseline is 0. Goal is to enroll 50 participants in ARAD for the first year of operation. Data Source: Program documentation **Milestone 2 Estimated Incentive Payment (max amount): $312,371**		**Milestone 3:** **I-1**: **Decrease admission/readmission to criminal justice system due to substance abuse issues.** Metric I-1.1: Decrease preventable substance abuse admissions/readmissions in the target population by 5% Baseline: Pre-test ARAD participants one year prior to program admission; Post-test after completion of ARAD project and note 5% reduction Data Source: Documentation, pre/post test results, coordinating documentation with criminal justice agencies **Milestone 3 Estimated Incentive Payment (max amount): $318,001**	**Milestone 4:** **I-2**: **Completion of the ARAD treatment program and evaluation of effectiveness.** Metric I-2.1: 20% Completion rate of ARAD program by target population participants Baseline: 20% of total participants for the entire program history completing the ARAD project Data Source: Program documentation. **Milestone 4 Estimated Incentive Payment (max amount): $295,396**
Year 2 Estimated Milestone Bundle Amount: $ 312,789	**Year 3 Estimated Milestone Bundle Amount: $312,371**		**Year 4 Estimated** Milestone **Bundle Amount: $318,001**	**Year 5 Estimated Milestone Bundle Amount: $295,396**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):				**$1,238,557**

Project Title: 2.3.1 Redesign primary care in order to achieve improvements in efficiency, access, continuity of care, and patient experience
Performing Provider: Cogdell Memorial Hospital/136330107
RHP Unique Identification Number: 136330107.2.1
Project Components: 2.3.1.a-c

Provider: Cogdell Memorial Hospital is a 49-bed sole community hospital serving a 30 square mile radius and a population base of almost 16,000.
Interventions: This project will call for the building of a new primary care clinic designed to so patient flow will be optimized, implementation of a walk-in clinic, development of a central scheduling process where patients can schedule all services by dialing one number.
Need for Project: Currently our clinic is located off site and with this project it will be brought back on site and will allow for patients to go see the provider and go down the hall to get an ancillary test. Also, it calls for the development of a central scheduling department so patients can get all services needed scheduled at one time. The new clinic will allow for more providers and have a walk-in clinic as part of it.
Target Population: Our target population is those patients who cannot get an appointment within 24 hours and those who do not have insurance. Currently, our clinic sees about 30% Medicare, 20% Medicaid and Medicaid Managed Care, 33% Managed Care, 15% self-pay and 2% other. Our clinic not only handles primary care, but OB and of the 215 deliveries we do a year approximately 85% of them is Medicaid.
Category 1 or 2 expected patient benefits: In DY 4 CMH, will be able to reduce patient wait times for primary care appointments to a little over a day from 2 days and in DY 5, CMH will be able to track no call/no shows and with this CMH will be able to reduce these rates by 5% as well as further reduce appointment times to 1 day or less.
Category 3 Outcomes: For IT 12.1 – In our population we have a population in which women make up almost half of the population and of this approximately 65% are above 24 years of age. The goal will be to have over 85% of all patients needing a mammo annually to have one.
For IT 12.3 – There is over 16,000 in population and by having better access and more timely service CMH will be able to get patients in and do more screening exams annual on the required patient population. The goal is to have 65% of all patients needed the annual screenings by DY 5.
IT 12.4 – There is approximately 3,000 patients who are 65 years or older and of this approximately half or just over half have received the pneumonia vaccination. Our goal is to get the patients into the clinic more timely and make this part of their annual checklist to ensure all patients who reach the age of 65 or higher are getting their pneumonia vaccinations.

Project Title: 2.3.1 Redesign primary care in order to achieve improvements in efficiency, access, continuity of care, and patient experience
Performing Provider: Cogdell Memorial Hospital/136330107
RHP Unique Identification Number: 136330107.2.1
Project Components: 2.3.1.a-c

Project Description: We propose to develop a process to redesign access to our primary care providers. To accomplish this we plan on implementing a "walk-in" clinic to decrease non-emergent care seen in our emergency department as a short term goal and build a new clinic that will be an addition to the hospital in order to streamline all care to include Cogdell Family Clinic, the "walk-in" clinic, emergency services and ancillary services. The new clinic will have more room to accommodate new providers and the patients will having easier access getting all the care they need in one setting therefore improving patient flow, patient care and patient satisfaction. To create the walk in clinic it will require at least 1 primary provider to be hired on as well as the clinic will start Friday thru Sunday from 8:00 am – 8:00pm. Also, we will implement a one stop centralized scheduling process where a patient calls in to schedule an appointment, get registered for all services, not just primary care. This will require the purchase of new equipment such as cubicles and computers as well as an area to house approximately 6-8 employees. We will purchase the new equipment approximately $100,000 - $150,000 initially and ongoing from there. These employees will handle the scheduling for any and all patients who might come to the hospital for outpatient services or clinic services. This adds up to approximately 45,000 – 50,000 visits. In looking at expectations, we expect to start with the clinic first in going to centralized scheduling and get them all on it and be able to reduce the time to get in from 4-5 days to same day over the next four years. For outpatient visits we hope to start around approximately 40-50% of all outpatient test (approx.. 20,000 total) and work to 75-85% of all outpatient test being scheduled and pre-registered at the end of DY 5.

In Scurry County we face several challenges with patients needing easier access to be seen for chronic and non-chronic healthcare problems. Implementing a "walk-in" clinic and building a new clinic in a new location (currently several blocks away) within the hospital will allow the patient easier access for all care needed. "One Stop Shop" for care. This will allow the patient to have care given in a timelier manner for provider care as well as ancillary are to include lab, radiology, respiratory therapy care, etc. We have approximately 16,000 patients in our service area with about 4,000 – 6,000 with chronic conditions who need regular medical treatment.

The implementation of this project will address the challenges as listed above. Redesign of primary care's first step will be to implement a "walk in" clinic. By the implementation of the "walk-in" clinic and improving access to care in the primary care

setting will also increase the opportunities to prevent disease and treat in a timelier manner to prevent patients from becoming extremely ill with chronic conditions and other conditions out of the ED and hospital. The hospital will involve case management to assist with the process with discharged patients to educate patients and following up with patients regarding care after they are dismissed from the hospital (i.e., follow up appointments, medication administration, etc.) to also eliminate possible readmissions. This project will tie with Expanding Primary Care Capacity as well.
Our five (5) year expected outcome for this project is to improve the redesign of primary care for patients to be seen in the "walk-in" clinic as a short term goal and the proximity of Cogdell Memorial Hospital and Cogdell Family Clinic (Rural Health Clinic) as a long term goal. Both areas short and long will assist with patients being seen for all healthcare needs (lab, radiology, etc.)
This project is related to the regional goals by improving the capacity of primary care, reduce readmissions, patients having to be transferred to tertiary care facilities by patients being seen in the appropriate setting in a timely time frame. Also, the improvement will help CMH better serve the low income and uninsured. We will track this information using our QAPI process to ensure we are getting more patients seen, more timely and having better outcomes.

Starting Point/Baseline: Our primary service is approximately 16,000 in the Scurry County region of which the hospital sees approximately 8400 patient in the ED each year and of this number approximately 2,500 or more is non-emergent, and utilizing the ED due to lack of primary care capacity. Cogdell Family Clinic provided approximately 20,000 patients in 2011. We have recently lost two (2) more providers adding to our crisis of needed providers. Due to this additional loss we have noted more patients travelling a 30 to 90 mile range for primary care or not receiving care at all. The hospital and clinic have noted a decrease in other services (i.e., lab, radiology, etc.) with the decrease of primary providers. The short term strategic goal for this is diligent primary care provider recruitment to resolve this crisis of approximately 2-4 primary care providers over the next four years. The long term strategic goal is for the hospital is to recruit an additional three (3) primary care providers over the next five (5) years and the goal with full capacity of primary providers the clinic will be able to grow approximately 4,000 to 6,000 visits a year. Another long term strategic goal is to build a new clinic with a new design in order to assist with recruitment and retention efforts. Currently, the clinic is seeing 4-5 day wait time for patients to get into see a physician as well as with the shortage in providers, having to turn away patients who are needing to be treated. This causes an increase in ER utilization, which the hospital has seen over the last couple of months going from an average of 700 a month to over 750 a month as well as some patients going elsewhere to find primary care services. Thru the development of a walk in clinic, we expect to be able to treat simple conditions and approximately 5,000 – 6,000 patients a year to start off with and grow from there. This will take a big part away from the primary care clinics and allow them to get the more chronic conditions in more timely and help us get to the goal of same day appointments.

Rationale: The project option chosen by CMH is very critical to its community and its ability to provide services need by the community. CMH will be address to address the core components thru a) the implementation of a patient centered scheduling model in our clinics and hospital to ensure all tie in together, b) by building the new clinic, CMH will re-design its flow and to help improve the throughput for patients to ensure more can be seen timely and lastly c) CMH will conduct a quality improvement process on the redesign of primary care and access to it to ensure patients will be seen more timely as well as they will be able to access the other continuity of care and improve their overall patient experience. CMH will be addressing a community need of CN.1 and CN.6. In project 2.3, the redesign of the new clinic and the hospital will address the following process milestones: P-1.1 and P-1.2, thru the redesign our primary care we will be able to track no-show rates and drop them from over 25% to below 15% as well as we will be able to get patients scheduled a lot quicker by going to a centralized scheduling system and get patients in by the third next available appointment. For the improvement milestones CMH will look at the following: I-11, again addressing getting patients into the clinic and seen by 2 days and I-12 the reduction of no show rates to drop from over 25% to below 15% over the five year time. CMH will be developing new initiatives thru the development of a centralized scheduling process, by redesigning the clinic and relocating it to the hospital, CMH is brining patient centered care to our clinic patients to allow them to have better access to all levels of care more timely, again another new initiative, and thru the QI portion of this project CMH will be enhancing the initiative of quality care and customer service. CMH has determined to value each based on the need of the community and on various patient survey results. Thru review and discussion CMH came up with the priorities to address the patient care, satisfaction of care and the most effective way to reduce cost. In conjunction with project 1.1.2, CMH valued this project less due to the fact, it will be related to 1.1.2 but it will take a different direction to get improved results. It is an important project, but not as critical as 1.1.2.

- **Related Category 3 Outcome Measure(s):**
- For IT 12.1 – In our population we have a population in which women make up almost have of the population and of this approximately 65% is above 24 years old. In order to ensure and help provide annual breast cancer screenings for our patients they will need to get into a primary care provider to get the order. By increasing the number of providers and by developing a walk in clinic, CMH can develop programs to encourage this and work with the radiologists reading the exam to offer special prices during breast cancer awareness month as well as provide state of the art technology with a digital mammogram.

- For IT 12.3 – There is over 16,000 in population and by having better access and more timely service CMH will be able to get patients in and do more screening exams annual on the required patient population.
- IT 12.4 – There is approximately 3,000 patients who are 65 years or older and of this approximately half or just over half have received the pneumonia vaccination. Our goal is to get the patients into the clinic more timely and make this part of their annual checklist to ensure all patients who reach the age of 65 or higher are getting their pneumonia vaccinations.

Relationship to other Projects: This project will be closely related to project 2.3, Redesigning primary care. By building the clinic on site, patients will have the ability to get all of their services needed in one place and during the same clinic visit. By doing this, providers will be able to see patients more timely any issues the patient maybe experiencing will be addressed timely. Thru the redesign of the new clinic, this will help improve the patient flow and allow CMH to see more patients.

Relationship to Other Performing Providers' Projects in the RHP: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways • Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties • Further develop and maintain a coordinated care delivery system • Improve outcomes while containing cost growth Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project impact one or more of the goals? • Does the project primarily impact Medicaid and/or uninsured residents? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**4**
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project address one or more community need? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**3**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in • Outreach to the targeted population • Patient visits/encounters • Providers recruited/trained • Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**

Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: • Human resources • Equipment purchase and maintenance • Legal and professional fees • Time to implement • Risk assessment • Organizational priorities	**3**

136330107.2.1	2.3.1	2.3.1.a-c	Redesign Primary Care
Cogdell Memorial Hospital			136330107
Related Category 3 Outcome Measure(s):	136330107.3.2 136330107.3.3 136330107.3.4	IT 12.1 IT 12.3 IT 12.4	Breast Cancer Screening Colorectal Cancer Screening Pneumonia vaccination status for older adults

DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	DY 5 (10/1/2015-9/30/2016)
Milestone 1: P-1. Milestone: Establish baseline data for each: patient appointment 'no-show' rates, days to third-next available appointment, and primary care visit cycle times, currently we are seeing approximately 15-20 no shows a day and another 10-15 cancellations a day. P-1.1. Metric: Baseline patient 'no-show' rates a. Numerator: Number of patients that did not show for a scheduled appointment (for any reason) b. Denominator: Number of patients scheduled Baseline/Goal: Reduce patients time to get into to see a physician by 1 day from 4-5 days to 3-4 days and reduce no call/no shows by from approximately 25-30 a day to 20-25 a day Data Source: Hospital/Clinic Records Milestone 2:	Milestone 3: P-5. Milestone: Train staff on methods for redesigning clinics to improve efficiency P-5.1. Metric: Number or proportion of staff trained a. Numerator: Number of relevant primary care clinic staff trained b. Denominator: Total number of relevant primary care clinic staff Baseline/Goal: Reduce patients time to get into to see a physician by 1 day from 4-5 days to 3- 2 and reduce no call/no shows by another 15-20 patients a day from the base line of 25-30 Data Source: : Hospital/Clinic Records Estimated Milestone 2 Incentive Payment: $311,468	Milestone 4: P-9. Milestone: Develop/implement a system for protocol driven automatic patient reminders (must select at least one metric): P-9.1. Metric: Document system and processes to implement [P-9} Goal: Reduce patients time to get into to see a physician by 4-5 baseline days to 1-2 days and reduce no call/no shows and cancellations from the initial baseline of 25-30 to 10-15 a day Data Source: : Hospital/Clinic Records Estimated Milestone 4 Incentive Payment: $155,493 Milestone 5: [I-1] I-12. Milestone: Reduce patient appointment no-show rates to less than 10% or less currently we are at	Milestone 6: [I-3] I-13. Milestone: Identify and provide follow-up contact to patients who have missed appointments, are overdue for care, or are not meeting care management goals I-13.1. Metric: Follow-up contact rate (the percentage of patients with appointments booked prior to the actual day of clinic who did not show up for their scheduled visit and received a follow-up contact) a. Numerator: Number of patients who missed an appointment in a and received a follow-up contact. b. Denominator: Number of patients who missed an appointment in a session. Goal: Reduce patients time to get into to see a physician from baseline of 4-5 days to same day of initial call. Reduce no shows and cancellations to less than 10 per day from the initial 25-30

136330107.2.1	2.3.1	2.3.1.a-c	Redesign Primary Care
Cogdell Memorial Hospital			136330107
Related Category 3 Outcome Measure(s):	136330107.3.2 136330107.3.3 136330107.3.4	IT 12.1 IT 12.3 IT 12.4	Breast Cancer Screening Colorectal Cancer Screening Pneumonia vaccination status for older adults

P-1. Milestone: Establish baseline data for each: develop centralized scheduling department to start with clinic registrations and pre-registrations and move to outpatient scheduling and pre-registrations. This is approximately 40,000 – 50,000 patients a year and of this we intend to hit 75% of clinic over the time and move to outpatient pre-registrations P-1.1. Metric: Baseline patient 'no-show' rates a. Numerator: Number of patients scheduled for visits b. Denominator: Number of patients pre-registered Baseline/Goal: Achieve 75% of clinic pre-registrations once it goes live in the summer of 2013 Data Source: Hospital/Clinic Records Estimated Milestone 1 Incentive Payment: $304,536		15-20% for no shows and another 15% for cancellations. I-12.1. Metric: No-show rate a. Number of patients that did not show for a scheduled appointment (for any reason) b. Denominator: Number of patients scheduled Baseline/Goal: Reduction of no show rates by over 5% Data Source: Hospital/clinic records Estimated Milestone 5 Incentive Payment: $155,493	Data Source: : Hospital/Clinic Records Estimated Milestone 6 Incentive Payment: $251,106
DY 2 Estimated Milestone Bundle Amount: $304,536	DY 3 Estimated Milestone Bundle Amount: $311,468	DY4 Estimated Milestone Bundle Amount: $310,986	DY5 Estimated Milestone Bundle Amount: $251,106
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5 $1,178,096			

Project Option: 2.9.1 Establish/Expand a Patient Care Navigation
Performing Provider: Covenant Children's Hospital/127319504
Unique Identification Number: 127319504.2.1
Core Components: 2.9.1. a-e

- Provider: Covenant Children's Hospital, the only licensed children's hospital in the region, is an 82-bed hospital in Lubbock, Texas, serving a 64 county area. It is one of only 8 certified in the State of Texas.
- Intervention(s): This project will implement a home-based patient navigation program for children with moderate to severe asthma through individualized educational support and resources that will facilitate medication adherence and PCP follow-ups.
- Need for the project: Covenant Children's has approximately 750 children with asthma being treated annually. These children account for a combined school absence days per year of 1860 and a combined loss of parent's productivity of $213,750/year.
- Medicaid and Uninsured Target population: The target population is our patients (400) that need navigation for asthma are approximately 50% of our patients are either Medicaid eligible or uninsured.
- Category 1 or 2 expected patient benefits: The project seeks to provide children with asthma, patient navigation services which will impact from baseline of 0 to 400 by DY5. We expect to enroll 200 patients in DY 3, 400 by DY 4 and 600 patients who suffer from asthma by DY 5. In addition, ED documentation will indicate that 200 patients were educated about establishing a PCP in DY 3 and 400 by DY 400. We will also refer 200 patients in DY 3 from the ED to a PCP and 400 in DY 5. The total number of patients expected to be impacted by this program by DY 5 is 1,000.
- Category 3 outcomes: IT-9.3 Our goal is to reduce the Asthma ED visits from baseline by 10% by DY4 and 20% by DY5.

Project Option: 2.9 Establish/Expand a Patient Care Navigation: Covenant Children's Hospital Asthma Navigation Program
Performing Provider: Covenant Children's Hospital/127319504
Unique Identification Number: 127319504.2.1
Core Components: 2.9.1. a-e

- **Project Description:** Children with moderate or severe asthma, particularly those who are minorities and/or middle to lower socio-economic status often encounter significant practice and health system barriers to accessing quality care. Covenant Children's Hospital will provide individualized, cost-effective ways to reduce obstacles to care by providing social and medical support through a home-based Asthma Navigation Program for Children. Navigators will provide educational support to patients and families through education about disease management, they will facilitate medication adherence, and they will identify and facilitate resource procurement and improve communication between providers. We expect to enroll 200 patients in DY 3, 400 by DY 4 and 600 patients who suffer from asthma by DY 5. In addition, ED documentation will indicate that 200 patients were educated about establishing a PCP in DY 3 and 400 by DY 400. We will also refer 200 patients in DY 3 from the ED to a PCP and 400 in DY 5. The total number of patients expected to be impacted by this program by DY 5 is 1000. Internal data identified approximately 600 patients with asthma who were frequent (more than 2 visits per year) utilizers in the ED from 04/01/2011 through 04/01/2012.

  The navigation team will consist of RN care coordinators working closely with patient navigators who will be recruited from a cadre of certified community health workers. This home visitation model will target 66% (400 out 600 ED frequent utilizers) through referral from the ED and inpatient case managers. Additionally, referrals are expected to come from local pediatricians through an established referral system. Covenant Children's Hospital Asthma Navigation Program will coordinate the care of the pediatric patients with asthma by working with the parents in a home setting to identify and establish strong relationships with their PCPs. The navigator team will coordinate post-hospitalization and post-ED follow up visits with the PCP by making sure patients have transportation to the visit and will provide taxi or bus vouchers as needed. They will assist the parents of uninsured children in making payment arrangements and utilizing the local federally qualified health center when possible. The patient navigators are trained to deliver culturally appropriate education and resources; therefore, making sure that the patient's hierarchy of needs is met, they can focus on facilitating behavior changes (for parents) through motivational interviewing. Through assistance for parents with resources attainment and facilitation of behavior changes, hospital potentially preventable hospitalizations and readmissions and ED revisits, related to an asthma diagnosis, will be reduced. Parents will be educated to recognize asthma triggers, instructed how to manage those triggers properly, be enabled to differentiate when to take the child to the ED and when to make a PCP appoint and most importantly, educated about medication adherence. The navigators will ultimately act as a liaison between the health care providers and the patient, while diverting unnecessary ED visits and establishing PCP utilization and providing education that will prevent exacerbations.

The Covenant Children's Hospital Asthma Navigation Program achieves the goals of RHP 12 by utilizing community health workers as patient navigators to provide enhanced social support and culturally competent care to vulnerable and high-risk population.

- **Starting Point/Baseline:** Childhood asthma has both direct costs and indirect costs associated with it. In terms of direct costs most Children's Hospitals base this on the total costs for caring for Children in the Emergency department (estimated at $600 per ED encounter) and the total costs for caring for children with asthma as an inpatient (estimated to be at $6600 per inpatient encounter). In Fiscal Year 2011 the total cost for caring for children with asthma at Covenant Children's was estimated to be $2,307,000. This has increased by 12% in FY 2012 to an estimated $2,587,200. Indirect costs include missed days from school and parents' loss of productivity. In a study by the CDC, it was estimated that on average there are 2.48 school absence days annually per child with asthma. In that same study, it was estimated that parents' loss of productivity costs on average $285 per child with asthma annually. Covenant Children's has approximately 750 children with asthma being treated annually. We would estimate that on average these children account for a combined school absence days per year of 1,860 and a combined loss of parents' productivity costing approximately $213,750 per year. Through this project we will enroll 600 patients into a Patient Navigator program and educate/refer another 400 to a PCP for a total of 100 patients served by the navigation program that will reduce both direct and indirect costs associated with childhood asthma.

- **Rationale:** This initiative was selected due to the results of the 2011 community health needs assessment conducted by Covenant which identified the need for strategic care for asthmatic pediatric patients. Another community health needs assessment conducted by a local federally qualified health center, Community Health Center of Lubbock, identified the lack of links to services as one of the top 5 community needs. The RHP 12 needs assessment identified high incidence of asthma care issues. A culturally competent asthma patient navigation program would fill in the gaps identified in these needs assessments.

  Covenant Children's Hospital has selected project option 2.9.1 and will include all required core components (see below). As identified in our Community Health Needs Assessment, CN.10, there is a growing need for quality and coordinated care and treatment of children with asthma. Additionally, there are a corresponding high number of potentially preventable asthma readmissions in the Children's Hospital and asthma revisits in the Emergency Department. Covenant Children's will develop a new patient navigation program for pediatric asthma management. We will implement a new patient and family centric paradigm to facilitate behavioral change among patients with asthma and their families through the use of trained patient navigators where motivational interviewing is the vehicle utilized to deliver targeted education and assist in behavior change for better disease management in a home setting.

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
Pediatric Asthma primary and secondary discharges from the ED for FY 2011 and FY 2012 for ages 2-20 (internal hospital data base) identified 3,724 ED visits and 403 inpatient encounters. This data will be used to establish an effective referral system. A navigation team will be deployed to provide culturally competent education and resources for patients identified with Asthma. The EMR can flag patients that have been to the ED and processes will be put in place to do a warm-hand off from the ED staff into the navigator program. In addition to recruitment from the ED, the inpatient RN Asthma coordinator will refer patients being discharged from the hospital into the program through a warm hand-off system. Navigators recruited will be trained in cultural competency using the Culturally and Linguistically Appropriate Standards (CLAS).

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
A team approach will be used to deploy an innovative team. An ED Case Worker will identify and refer patients to a team of RN Care Coordinators and certified community health workers trained as navigators. In addition an RN Asthma Coordinator, who will be part of the team, will also refer patients at the bedside into the program. These navigators will be recruited from a pool of local certified community health workers trained in eight core competencies which include: advocacy, interpersonal skills, teaching skills, service coordination, organizational, communication, capacity building and knowledge base. Additional intermediate training will be provided upon hire to the whole team including RNs that will include motivational interviewing, chronic disease management, community resources, cultural competency and data collection. This team will work closely with the ED providers, PCPs, ED Case Worker and the inpatient RN Asthma Education Coordinator to facilitate a smooth transition between services.

c) Connect patients to primary and preventive care.
The risk for increased ED utilization and hospitalizations lies in the lack of connection between an asthma patient and their PCP. Many patients do have identified PCPs and others who do, cannot access their services after hours. The Asthma Navigator team will work as a liaison to establish a bridge between the patient and their PCP. If patients do not have an identified PCP, the team will assist with identifying a PCP and work towards facilitating that relationship. Low health literacy is found to be a culprit in poor disease management. The Navigator team will assess the parent's health literacy level and provide appropriate education resources. Red flags will be introduced to the patient and their families which will help them assess and decide when a patient should be taken to the ED or can more appropriately be seen in the primary care setting. Most importantly, patients and their families will receive education regarding asthma triggers and how to avoid these triggers for better quality of life. Lack of medication knowledge and the importance of adherence is another problem among this group. The navigator program will assess medication knowledge and facilitate goals that lead to positive behavior changes which ultimately improve medication adherence. The RNs on the navigator team will do medication

reconciliation in the home and act as a liaison between the patient and their PCP when new medications are added or changes are made in their current medication regimens.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. Access to care management through the Covenant Children's Hospital Asthma Navigation Program will be available through a referral system within the ED as well as within the inpatient setting. A warm hand-off system will be established between the ED, Hospital personnel and the navigator program personnel. A smooth referral system from Pediatric practices for patients identified for direct admission into the navigation program that may need education and resources will also be established. The Covenant Children's Hospital Asthma Navigation Program will provide goal-oriented education and disease self-management. During each home visit, the patient's parents will identify goals that they would like to work on to improve disease management. Navigators use the Procheska and DiClemente stages of change model, more specifically the "Ruler" which guides the patient's parent to identify goals that are "important" to them and that they "feel most confident" in achieving. In addition the navigators guide the parents to identify strengths and barriers to achieving those goals. This process facilitates individualized behavior change at a pace set by the parent/patient which leads to greater success in achievement.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
A care registry will be used to capture care management documentation as well as disease outcomes. Behavior changes are measured through validated survey tools and will be measured and reported. A robust quality management system will be implemented to capture trends, cost and savings. Interdisciplinary team meetings will take place on a monthly basis that will identify "lessons learned" and implement new strategies to address opportunities for improvement. Covenant Children's Hospital has identified coding issues for ED and inpatients stays, quality improvement processes will be implemented to address the need for more accurate reporting mechanisms. Medicaid and uninsured patients will be targeted for admission into the program.

- **Challenges**
  Covenant Children's has identified three challenges to enrolling pediatric patients into the Hospital Asthma Navigation Program. Recognized barriers include recruitment of patients, healthcare provider buy-in and recruitment of educators. To overcome the difficulty of patient enrollment, we will identify potential patients not only through inpatient and Emergency Department visits but through outreach with our community healthcare providers. Through strategic marketing, we will seek referrals from

Federally Qualified Health Centers (FQHC), Child Protective Services and primary care physicians. Lubbock currently has two FQHCs that we will seek a partnership with for enrollment into the Asthma Navigation Program.
Covenant Children's will achieve buy-in from local healthcare providers by demonstrating the quality and value gained when patients and families are thoroughly educated on their child's disease process. With increasing demands placed on primary care providers, education continues to burden the time of physicians. The Asthma Navigation Program will seek to alleviate the stress of education on physicians, while simultaneously providing best care to patients. Physician offices and FQHCs frequently have long wait times for families to be seen by their healthcare provider. Healthcare providers will gain benefit of enrolling their patients in the Asthma Navigation Program as a way for their patients to receive the excellent and complete care they deserve. Covenant Children's will seek partnerships with local healthcare providers and demonstrate the quality and value of the navigation program. Buy-in will come from the noted decreased Emergency Department visits and increase in asthma control and medication adherence. Ultimately the goal of behavior change will lead to patient and family empowerment and confidence in managing the child with asthma.

Covenant Children's plans to seek partnerships in the community to accommodate the annual enrollment of at least four hundred participants each year in the Asthma Navigation Program. The community of Lubbock has several opportunities outside the hospital to form partnerships and recruit educators for our navigation program. The Lubbock area has three nursing schools and two schools offering degrees in respiratory care with opportunities available to fulfill community health needs. Lubbock has the Texas Tech Health Science Center which houses the School of Medicine and School of Pharmacy. Both programs have medical students and residents also needing to fulfill community service requirements. Covenant Children's plan to pursue partnerships with area schools and invite students and residents to fulfill their community health requirements while improving the lives and knowledge of children with asthma. Opportunities will also be sought within our organization. Our employees embrace the hospital vision and are committed to improving and creating healthy communities. In addition to the education team members provide at asthma camps and asthma in-services, it is our hope that personnel will assist with educating children with asthma in our community. Through our outlined strategies, we are confident we will overcome the three identified barriers to enrollment into the Asthma Navigation Program

- **Related Category 3 Outcome Measure(s):**
  OD- 9 Right Care, Right Setting
  IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure)

Covenant Children's Hospital currently has a relatively high rate of asthma revisits to the pediatric Emergency Department, 21%. As some visits are potentially preventable, we expect to reduce the potentially preventable ED visits for pediatric patients with chronic asthma.

Two similar pilot projects have been conducted in the outpatient and inpatient setting in Lubbock. The outpatient setting project documented in the Online Journal of Issues in Nursing proved to be successful in decreasing ED visits and hospitalization for patients with Asthma as well as biometric and behavioral changes for patients with Hypertension and Diabetes (Esperat, M. C.; Flores, D.; McMurry, L.; Feng, D.; Song, H.; Billings, L.; Masten, Y. [May 31, 2012] "Transformacion Para Salud: A Patient Navigation Model for Chronic Disease Self-Managment" OJIN: the Online Journal of Issues in Nursing Vol. 17, No. 2, Manuscript 2.). The goal of the second pilot project with two local hospitals was to prevent 30 day readmissions and ED visits for patients without Primary Care providers who were admitted with Hypertension, Diabetes, CHF, COPD or Asthma. This latter project which is still in the pilot stage has proven successful thus far with approximately 30 patients enrolled and only 1 readmission and 1 ED visit.

Other studies have indicated that navigators helped low-income women overcome barriers, such as lack of health insurance, associated with early breast cancer detection. On average it took women 42 days to receive a diagnosis while women that were navigated were diagnosed within 27 days. Reducing delays in diagnosis and delays in treatment can improve patient's health outcomes and ability to manage chronic conditions.

By providing a new patient and family centric paradigm to facilitate behavior change among patients with asthma and their families, we will improve the health outcomes of low-income populations. Our estimate is that Medicaid and or low-income patients will be the 74% of those enrolled in the program. This program will serve as the bridge or liaison to a population of people who have problems navigating the health care system effectively and who also lack the resources to do so.

- **Relationship to other Projects:** Covenant Children's Hospital is the only licensed Children's Hospital between El Paso and Fort Worth. It is the West Texas Region's only licensed Children's Hospital and one of only 8 in the State of Texas. Covenant Children's Hospital serves a 64-county area. With an Asthma navigation program in place, we will expand services beyond the walls of our hospitals and clinics into the community as Covenant Medical Center has identified the same goals in 139461107.2.2: Covenant Adult Patient Navigation Program, 139461107.2.3: Covenant Transitional Outpatient Psychiatric Clinic, and 139461107.2.4: Covenant Outpatient Palliative Clinic. Category 4 Outcome Domains including PPAs and PPRs will also be impacted by these interventions.

- **Plan for Learning Collaborative:** Covenant's Children's Hospital, being the only licensed Children's Hospital in the region, can serve as a learning hub for RHP 12 and adjacent regions. We are ready to offer trainings and education to Family Practice physicians as well as pediatricians and other medical staff on the front lines across our rural region. Pediatric Asthma is not local to Lubbock and enabling other healthcare providers to determine appropriate care will also improve patient health outcomes. Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the

ways they have successfully gathered relevant data and ultimately better served the population in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:** RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines, the valuation considers that the Covenant Children's Hospital Asthma Navigation Program aims to expand care beyond the walls of the hospital to ensure patients continue to receive high-quality, patient-centered care post-inpatient admission. Two patient navigation projects were piloted at Covenant Health System and University Medical Center. Covenant Health System piloted two patient navigation projects which have indicated lower readmissions and ED visits and associated healthcare costs for patients enrolled. This project will create a new patient navigation program for a growing, high cost Medicaid and uninsured target population of children with asthma. There will be cost avoidance for public payers as well as improved maneuvering through the ever expanding continuum of care for children and their families as well as improved patient outcomes. According to the CDC and DSHS, total asthma costs increased 6% from 2002 - 2007. DSHS estimates that in 2009, there were 872,000 children (13.3%) with lifetime asthma and 538,000 children (8.2%) with current asthma statewide. They also estimate that asthma affects more children than any other chronic disease and is one of the most frequent reasons for hospital admissions among children. The hospitalization rate for Texas in 2007 was 10.9 per 10,000 Texas residents, accounting for more than 25,000 hospitalizations and an estimated $446.8 million in total hospital charges. (Source: Asthma Morbidity and Mortality in Texas by Whitney Harrison, M.P.H. Epidemiologist, Texas Asthma Control Program, Department of State Health Services and Texas Asthma Burden Report).

  Childhood asthma has both direct costs and indirect costs associated with it. In terms of direct costs, most Children's Hospitals base this on the total costs for caring for Children in the Emergency department (estimated at $600 per ED encounter) and the total costs for caring for children with asthma as an inpatient (estimated to be at $6600 per inpatient encounter). In Fiscal Year 2011 the total cost for caring for children with asthma at Covenant Children's Hospital was estimated to be $2,307,000. This has increased by 12% for FY 2012 to an estimated $2,587,200. Indirect costs include missed days from school and parents' loss of productivity. In a study by the CDC it has been estimated that on average there are 2.48 school absence days annually per child with asthma. In that same study, it is estimated that parents' loss of productivity costs on average $285 per child with asthma annually. Covenant Children's has approximately 750 children with asthma being treated annually. We estimate that on average these children account for a combined school absence days per year of 1,860 and a combined loss of parents' productivity costing approximately $213,750 per year.

  Covenant Children's Hospital Asthma Navigation Program will save cost while embedding an innovative program that will reduce fragmentation in access to care, improve outcomes through behavior change and maximum utilization of community resources. We estimate our baseline of 6,700 patients with asthma currently and plan to target enrollment of 100 into the navigator

program in DY 3, 300 patients in DY4 and 600 patients by DY5. We expect to refer 200 patients from the ED to PCPs in DY 4 and 400 in DY 5. Additionally, we expect to see 200 patients with PCPs in the navigation program in DY 4 and 400 patients with PCPs in the navigation program in DY 5. The total number of patients expected to be impacted by this program by DY 5 is 1,000**.** Similar to the Nurse Family Partnership, also a patient navigation program with in home visits, which in 2009 had cost estimates that to serve approximately 2,000 clients $9.4 million for 2 years, we estimate having served 1,000 patients at least 600 in the navigation program at a cost of $10 million over four years. Again referencing the Nurse Family Partnership's request for an additional $8.4 million to expand services to 200 more clients in the 2010-11 biennium, we believe this valuation is justified. (Nurse Family Partnership costs are reported by HHSC's Evaluation Report)

Unique Identifier 127319504.2.1	Project Option 2.9.1	Project Components 2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e	Project Title Covenant Children's Hospital Asthma Navigation Program 2.9 Establish/Expand a Patient Care Navigation Program
Covenant Children's Hospital			127319504
Related Category 3 Outcome Measure(s):	Unique Identifier 127319504.3.1	Reference Number IT-9.3	Outcome OD- 9 Right Care, Right Setting IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-2 Milestone: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. <u>Metric 1</u> P-2.1. Metric: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline/Goal: Establish the Covenant Children's Hospital Asthma Navigation Program and recruit RN Care coordinator and 2 patient navigators from cadre of certified community health workers in the community.	**Milestone 2** **P-3 Milestone: Provide Care management/navigation services to targeted patients** <u>Metric 1</u> P-3.1 Metric: Increase the number or percent of targeted patients enrolled in the program Numerator: Number of targeted patients enrolled in the program Denominator: Total number of target patients identified Baseline/Goal: Baseline of 6700 patients with asthma to target of 100 in DY 3, 300 patients in DY4 and 600 by DY5. Data Sources: Enrollment reports	**Milestone 3** Establish PCP education in the ED <u>Metric 1</u> P-6.2 Metric: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED. Numerator: Number of ED patients without a PCP documented in their medical record that receive (documented) education or resources) Denominator: ED patients without a PCP documented in their medical record. Baseline/Goal: Base line of 0 to target of 200 referred by DY4 Data Source: Enrollment reports and documentation in ED records Milestone 4 Estimated Incentive	**Milestone 5** Establish PCP education in the ED <u>Metric 1</u> P-6.2 Metric: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED. Numerator: Number of ED patients without a PCP documented in their medical record that receive (documented) education or resources) Denominator: ED patients without a PCP documented in their medical record. Baseline/Goal: From 200 in DY 4 to 400 in DY 5 Data Source: Enrollment reports and documentation in ED records **Milestone 5 Estimated Incentive Payment: $1,123,988.50**

Unique Identifier 127319504.2.1	Project Option 2.9.1	Project Components 2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e	Project Title Covenant Children's Hospital Asthma Navigation Program 2.9 Establish/Expand a Patient Care Navigation Program
Covenant Children's Hospital			127319504
Related Category 3 Outcome Measure(s):	Unique Identifier 127319504.3.1	Reference Number IT-9.3	Outcome OD- 9 Right Care, Right Setting IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Workforce development plan for patient navigator recruitment, training and education Milestone 1 Estimated Incentive Payment (maximum amount): $2,487,151		Payment: $1,360,617.50 **Milestone 4** I-6. Milestone: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. <u>Metric 1</u> I-6.4. Metric: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Baseline/Goal: Incrementally increase the number of patients with primary care providers from 0 to 200 by DY4.	**Milestone 6** I-6. Milestone: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. <u>Metric 1</u> I-6.4. Metric: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Baseline/Goal: Incrementally increase the number of patients with primary care providers to 400 DY5. Data Source: Performing Provider administrative data on patient

Unique Identifier 127319504.2.1	Project Option 2.9.1	Project Components 2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e	Project Title Covenant Children's Hospital Asthma Navigation Program 2.9 Establish/Expand a Patient Care Navigation Program
Covenant Children's Hospital			127319504
Related Category 3 Outcome Measure(s):	Unique Identifier 127319504.3.1	Reference Number IT-9.3	Outcome OD- 9 Right Care, Right Setting IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 4 Estimated Incentive Payment: $1,360,617.50	encounters and scheduling records from patient navigator program. Milestone 7 Estimated Incentive Payment: $1,123,988.50
Year 2 Estimated Milestone Bundle Amout: $2,487,151	Year 3 Estimated Milestone Bundle Amount: $2,713,348	Year 4 Estimated Milestone Bundle Amount: $2,721,235	Year 5 Estimated Milestone Bundle Amount: $2,247,977
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $10,169,711			

Project Option: 2.8.11 - Project Option: Sepsis
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.1

- Provider: Covenant Medical Center, largest health system in the region, is a 622-bed hospital in Lubbock, Texas, serving a 64 county area and a population over 1,200,000.
- Intervention(s): The project will implement a sepsis resuscitation and management bundle for treatment of severe sepsis and septic shock by providing training to staff and writing physician order sets.
- Need for the project: In a 6 month period, there were 575 cases of sepsis.
- Medicaid and Uninsured Target population: The target population will include 19.5% Medicaid eligible as well as approximately 6% uninsured.
- Category 1 or 2 expected patient benefits: The project seeks to decrease the number of patients who expire from sepsis/septic shock. Covenant Health Serves a referral population of ~1 million people. Covenant Medical Center is the largest tertiary care hospital in the 64 County RHP Region, with ~30,000 inpatient between our 2 Lubbock Campuses each year. During the 6-month baseline period CH cared for 575 patients with severe sepsis or septic shock. This would project to 1150 patients on an annualized basis. During the baseline, 68 patients (21%) died of severe sepsis or septic shock at our Lubbock facilities. This would project to 136 patients on an annualized basis. Our observed/expected mortality ratio during our baseline period was 1.26.
- Category 3 outcomes: IT-4.8 Our goal is to reduce mortality from sepsis from baseline to >1 by DY5. During DY4 the goal is to reduce Sepsis mortality by 15% to an O/E ratio of ~1.10. Based on an annualized 136 mortalities, this would be 20 less deaths per year in the Lubbock Region. The goal in DY5 is to reduce Sepsis mortalities by an additional 15%, to an Observed/Expected Ratio of 0.95.

Project Option: 2.8.11 - Project Option: Sepsis
Collaboration Project
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.1

- **Project Description:** Covenant Health, through our commitment to continual quality improvement, implemented a Sepsis Quality Initiative in 2012. This project was selected as it pursues the regional goals for access to quality care and engagement across providers for potential learning collaborative opportunities. This project was initiated using a multi-disciplinary LEAN Vertical Value Stream process to evaluate and to improve Covenant Health's recognition and treatment of sepsis. The Institute of Healthcare Improvement's Sepsis Resuscitation. Bundle was used as the foundation of our Sepsis Quality Initiative to design processes that would improve the recognition, treatment and outcomes for patients with severe sepsis and septic shock. Evidence-based protocols have been implemented, all relevant clinical staff across the four Covenant facilities will be trained initially and retrained yearly, and patient outcomes will be measured to achieve decreased mortality.

  As noted, this intervention includes implementation of the Sepsis Resuscitation Bundle for treatment of severe sepsis and septic shock. The program will be primarily based at our Lubbock campuses, Covenant Medical Center and Covenant Women's and Children's Hospital, with satellite programs at our Levelland and Plainview facilities. The physician leadership within our Clinical Effectiveness Program will write severe sepsis/septic shock physician order sets. We will educate and train all necessary staff in the appropriate evidence-based protocols. Our system needs additional improvement in the recognition and treatment of severe sepsis and septic shock, including the use of and compliance with evidence-based treatment protocols based on the Institute for Healthcare Improvement's Surviving Sepsis Campaign.

  Covenant Health Serves a referral population of ~1 million people. Covenant Medical Center is the largest tertiary care hospital in the 64 County RHP Region, with ~30,000 inpatient admissions between our 2 Lubbock Campuses each year. During the 6-month baseline period CH cared for 575 patients with severe sepsis or septic shock. This would project to 1150 patients on an annualized basis.

  During the baseline, 68 patients (21%) died of severe sepsis or septic shock at our Lubbock facilities. This would project to 136 patients on an annualized basis. Our observed/expected mortality ratio during our baseline period was 1.26 based on risk-adjusted data from the Premier database.

  As identified in the table below, we have selected to include a customized improvement milestone based on the recently proposed National Quality Forum's (NQF) metrics for the sepsis. As noted below, we will establish a baseline and expect to see improvements in our staff's meaningful utilization of the sepsis bundle. This will include obtaining lactate levels, drawing blood

cultures prior to antibiotics, and prompt administration of broad-spectrum antibiotics and 30ml/kg crystalloid for hypotension and/or a serum lactate >=4mmol/L within three hours of the recognition of severe sepsis or septic shock.

By DY 5 of the Waiver, we expect the use of the Resuscitation Bundle to lower the Observed/Expected Mortality ratio to < 1, and then we expect to maintain it. The Centers for Medicare and Medicaid Services Value-based Purchasing Program allows recognition for year on year improvement within an institution as well as for absolute achievement relative to its peer group. We plan to demonstrate initial year-to-year improvement. When the program is successful, we propose to maintain this improvement. The care improvement metrics will be acquired by chart review. We will obtain patient outcome data from the same database we use to report on Core Measures for Value-Based Purchasing to CMS (Premier). Thus, we will use the same database to report to both Medicare and Medicaid.

Covenant Health will implement the Sepsis Quality Initiative with training and education for early recognition and treatment in our main Lubbock campuses as well as the Plainview and Levelland Hospitals, which are UC only providers in RHP 12. Through this system-wide collaborative, Covenant would be able to establish other remote, evidence-based, best practice trainings related to Sepsis for interested RHP 12 providers.

- **Starting Point/Baseline:** From December 1, 2011, to May 31, 2012, which is the most recent 6 month period for which we have data post CMS approval of the 1115 waiver, Covenant Health had 575 cases of severe sepsis/septic shock. From January 1 to September 30, 2012, DY 1 of the waiver, we trained 1,384 health care providers, including 1,298 nurses and 60 physicians in the IHI evidence-based protocols addressing the recognition and management of Sepsis. We plan to hold ongoing sepsis trainings for Covenant Health staff and physicians, and incorporating sepsis training as a part of new clinical employee orientation. We will also hold ongoing retraining sessions for our staff. In DY 3, we will establish a baseline using data no older than December 2011 on the use of the proposed National Quality Forum's sepsis bundle. As outlined below under improvement milestones, we will then measure the meaningful utilization of the bundle in DY 4 and DY 5.

  As part of our Sepsis Quality Initiative, we will implement a system to establish the baselines, to implement evidence-based treatment strategies, to measure and to report the relevant data for patients with severe sepsis and septic shock back to their treating providers. Our goal is to improve our recognition and treatment of severe sepsis and septic shock to reduce mortality from these conditions, which is our Category 3 outcome measure.

- **Rationale:** In addition to RHP 12's Community Needs Assessment, including CN.1, CN.2, and CN.4, Covenant Health has identified the treatment of severe sepsis and septic shock as a gap in our current quality programs.

  Utilizing Project Area: 2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency and Project Option: 2.8.11 related to Sepsis gives Covenant Health the opportunity to provide training for our staff and consistent care for all patients who

present with severe sepsis and septic shock. Across our four facilities, Covenant Health will implement an evidence-based protocol that will lead to a reduction in mortality. Covenant will use the OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions, IT-4.8 Sepsis mortality and report improvement in mortality rates for this target population. As noted in the milestones related to the implementation of the Sepsis Resuscitation and Management Bundles, clinical staff will be trained to recognize and to respond more quickly to patients with sepsis. As noted by the IHI and other published studies, the use of these evidence-based protocols yields improvements in patient outcomes.

Through our commitment to continuous quality improvement, Covenant Health currently has a Clinical Effectiveness Program that is devoted to process improvement, with the commitment to improve the care and outcomes of our patients. This is being done across several conditions. Sepsis and septic shock are now a core part of this initiative. Our Clinical Effectiveness Program also has initiatives underway or in development for Medical and Surgical gastroenterological conditions, congestive heart failure, stroke and lower extremity joint replacements and fractures. An additional goal of the Clinical Effectiveness program is to reduce inappropriate variations in patient care. Covenant Health is committed to reducing the variation in the treatment of complicated diseases. Variations in care can lead to both overuse and underuse of appropriate services that in turn can increase the risk of complications and poor outcomes.

Improvement in the quality and treatment of Sepsis is a recognized local and regional need. As a tertiary care center that at least 24 rural and smaller hospitals in RHP 12, and an additional 9 rural and smaller hospitals in Eastern New Mexico rely on, it is critical that we improve the outcomes for patients with sepsis. Over the six months from December 1, 2011, to May 31, 2012, Covenant Health reported a combined Observed/Expected Mortality ratio of 1.26. This ratio is extracted from the Premier database, and consists of the risk-adjusted Observed/Expected mortality for patients who had severe sepsis or septic shock. The numerator consists of the number of patients who died of these conditions. The denominator consists of all patients at Covenant Medical Center who had the diagnosis of severe sepsis or septic shock. Thereby Covenant Health, through this initiative, is committed to improving patient care and related outcomes, with a primary goal of reducing mortality from severe sepsis and septic shock.

- **Related Category 3 Outcome Measure(s):**
  OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions
  IT-4.8 Sepsis mortality (Standalone measure)
  a. Numerator: Number of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.
  b. Denominator: Number of patients identified that month with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.
  c. Data Source: Performing Provider data

Covenant Health will use the Premier database to report this metric.

In congruence with the advances in the Medicaid APR-DRG system and Medicare MS-DRG payment structures, which pay providers based on their quality rates, Covenant has identified mortality as the patient outcome that best measures the strength and impact of the Sepsis Quality Initiative.

Covenant Health will establish a baseline measurement period for the treatment of severe sepsis and septic shock. The mortality rate will be risk-adjusted and used for comparison to our peer hospitals performance in the Premier database. Covenant Health believes that mortality rates greater than 1 are not an acceptable outcome for our patients. The goal of this initiative is to improve the quality of the care we provide to our patients with severe sepsis and septic shock, thereby decreasing the mortality in our institution to a ratio that is an absolute improvement year over year for ourselves and then to maintain relative outperformance in our peer group.

The Institute for Healthcare Improvement and others have shown the effectiveness of the Sepsis Resuscitation and Management Bundles, as documented in the references below:

1. Institute for Healthcare Improvement (IHI) Website, Surviving Sepsis Campaign http://www.survivingsepsis.org/What_You_Should_Know/Pages/default.aspx accessed July 26, 2012.
2. Institute for Healthcare Improvement. Sepsis Resuscitation Bundle. Available at http://www.ihi.org/knowledge/Pages/Changes/ImplementtheSepsisResuscitationBundle.aspx.
3. Resar R, Griffin FA, Haraden C, Nolan TW. Using Care Bundles to Improve Health Care Quality. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org).
4. Nguyen HB, Corbett SW, Steele R, et al. "Implementation of a Bundle of Quality Indicators for the Early Management of Severe Sepsis and Septic Shock is Associated with Decreased Mortality. " *Critical Care Medicine.* 2007. April; 235(4): 1105-1112.
5. Rivers, E.P., Katranji, M., Jaehne, K.A., Brown, S., Abou Dagher, G., Cannon, C. & Coba, V. (2012). Early interventions in severe sepsis and septic shock: A review of the evidence one decade later. *Minerva Anestesiologica,78(6),* 712-24.

- **Relationship to other Projects:** Quality improvements support and reach all levels of care in all settings of care across Covenant Health. Category 4 is designed to collect rates on 64 Potentially Preventable Complications (PPC). Continuous quality improvements, staff trainings and further implementation of best practices will impact all PPC rates.

The treatment of severe sepsis and septic shock is one of several performance improvement projects that Covenant Health has developed or is in the process of developing, as listed above. The primary Category 4 outcome that the Sepsis Quality Initiative project may impact is the All-Cause 30-day Readmission rate.

- **Relationship to Other Performing Providers' Projects in the RHP:** As noted above, Covenant Health will implement the Sepsis Quality Initiative with training and education for early recognition and treatment in our main Lubbock campuses as well as the Plainview and Levelland Hospitals, which are UC only providers in RHP 12.

- **Plan for Learning Collaborative:** As noted above, Covenant Health will implement the Sepsis Quality Initiative with training and education for early recognition and treatment in our main Lubbock campuses as well as the Plainview and Levelland Hospitals. Through this system-wide collaborative, Covenant would be able to establish other remote, evidence-based, best practice trainings for interested RHP 12 providers. Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the population in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.
- **Project Valuation:** RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines, the valuation considers that the Covenant Sepsis Quality Initiative is transformational in that it seeks to improve quality care for Medicaid, the uninsured, and all patients with sepsis as well as establish a foundation for ongoing learning and trainings on evidence based protocols.

  Every year, severe sepsis strikes about 750,000 Americans. It's been estimated that between 28 and 50 percent of these people die—far more than the number of U.S. deaths from prostate cancer, breast cancer and AIDS combined. According to the H-CUP Statistical Brief 122, septicemia was the most expensive reason for hospitalization in 2009, totaling nearly $15.4 billion in aggregate hospital costs. Septicemia was the sixth most common principal reason for hospitalization in the U.S. with 836,000 hospital stays in 2009. There were an additional 829,500 stays with a secondary diagnosis of septicemia, for a total of 1,665,400 inpatient stays.

  Based on these findings, Covenant Health expects there is a substantial opportunity to reduce morbidity related to sepsis in our population with this intervention. We estimate spending on sepsis to be around $50 million per year in our region and about $20 million within Covenant Health. Estimated cost per case is approximately $15,800 and our targeted cost per case is closer to $14,600, approximately 7.3 percent less. Covenant Health estimates potential cost savings for all payers to be around $1.5 million per year and is targeting a 5 percent reduction in costs in DY 4 and DY 5. However, because this is not a cost containment project , this will not be reported, but it is nonetheless anticipated. We do believe that the prevalence and associated costs further support the need for improvements in the recognition and treatment of sepsis.

We have identified mortality as our related Category 3 outcome improvement as this is our primary goal for this intervention and for our patients. Through the implementation of the Sepsis Quality Initiative, we will further develop and hold ourselves as providers accountable for improved quality of care and health outcomes. Additionally, we are committed to raising the bar within our peer group to increase quality and outcomes across all providers. Through the potential learning collaborative, we expect to be able to share in use of these approaches with our rural partners to promote the early detection and treatment of sepsis in the critical first hours. As noted previously, there are a number of reviews which support the improvement in outcomes when the sepsis bundles are implemented and treatment variation is limited. Our goal is to reduce our related, risk-adjusted mortality rate to less than 1 by DY 5. We have identified this as a national and peer group standard for our System.

As noted above, we began training almost 1,400 staff and physicians in DY 1. We plan to host training sessions at each of our four facilities in DY 2 and DY 3 and then also have at least new clinical employee training sessions each year. We estimate 2000 total staff throughout the system will receive some training in the best practices for recognizing and treating sepsis and septic shock. As the implementation of the bundles rolls on, we will have retraining efforts for staff that may be deficit in the utilization of the bundles, and then we plan to integrate quality training related to sepsis in all new staff orientations as part of our commitment to continual quality improvement. Training new staff and future leaders will also further Value-Based Purchasing concepts, including pay for performance and pay for outcomes.

This project is a collaboration project as it benefits regional transformation. In the lower region of RHP 12, the general practice in rural facilities is to transfer sepsis cases as soon as possible into Covenant Medical Center in Lubbock, thus expanding the scope of this project to include patient outcomes for all residents with an all-payer case mix throughout our referral area. In coordination with this effort, Covenant Hospital Levelland and Covenant Hospital Plainview have both invested their DSRIP allocations in this robust project at Covenant Medical Center that incorporates the Sepsis Quality Initiative System wide.

Unique Identifier 139461107.2.1	Project Option 2.8.11	N/A	Sepsis Quality Initiative Apply Process Improvement Methodology to Improve Quality/Efficiency: Sepsis
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.1	Reference Number IT-4.8	Outcome Sepsis mortality (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-8. Milestone: Complete our initial staff training at all 4 of our sites (Adult and Pediatric in Lubbock and the hospitals in Levelland and Plainview.) <u>Metric 1</u> P-8.1. Metric: Number of providers/staff trained a. Numerator: Number of providers/clinical staff trained b. Denominator: Total number of providers/clinical staff Baseline/Goal: Provide baseline training to our clinical staff to recognize sepsis and rapidly initiate aggressive treatment. We estimate at least 2000 staff trained system wide over the course of the project. <u>Metric 2</u> P-8.2. Number of trainings held Baseline/Goal: 1 Training class on each campus. Adult and Pediatric in Lubbock and the hospitals in Levelland and Plainview. In DY 1, we trained almost 1,400 staff. Our	**Milestone 3:** P-8. Milestone: Provide ongoing training to the staff at our 4 sites on an annual basis to maintain awareness and the skills to provide high-level sepsis care. This is in addition to new employee training. <u>Metric 1</u> P-8.1. Metric: Number of providers/staff trained a. Numerator: Number of providers/staff trained b. Denominator: Total number of providers/clinical staff Baseline/Goal: Provide initial training to all new clinical employees and continuing updates and knowledge reinforcement to our clinical staff. We estimate at least 200/year staff trained system wide in addition to our baseline total. <u>Metric 2</u> P-8.2. Number of trainings held Baseline/Goal: We expect at least 12 training sessions for new staff between the two Lubbock campuses each year. Yearly sessions will be held at Levelland and Plainview. Data Source: Curriculum or other training schedules/materials	**Milestone 6 :** I-X. Milestone: Percentage of patients with severe sepsis/septic shock where there is meaningful use of the Resuscitation Bundle. <u>Metric 1</u> I-X.1. Percentage improvement over baseline. a. Numerator*: Number of patients with severe sepsis/septic shock who have meaningful use of the Sepsis Resuscitation bundle at CMC. b. Denominator: All patients with severe sepsis/septic shock treated at CMC. Baseline/Goal: Initial review of charts revealed 575 cases in late 2011 to mid-2012. 40% meaningful use of the order set in patients with severe sepsis/septic shock will be achieved by DY4. Data Source: EMR/ Chart review of qualifying patients at CMC.	**Milestone 7 :** I-X. Milestone: Percentage of patients with severe sepsis/septic shock where there is meaningful use of the Resuscitation Bundle. <u>Metric 1</u> I-X.1. Percentage improvement over baseline. a. Numerator*: Number of patients with severe sepsis/septic shock who have meaningful use of the Sepsis Resuscitation bundle at CMC. b. Denominator: All patients with severe sepsis/septic shock treated at CMC. Baseline/Goal: Initial review of charts revealed 575 cases in late 2011 to mid-2012. 60% meaningful use of the order set in patients with severe sepsis/septic shock will be achieved by DY5. Data Source: EMR/ Chart review of qualifying patients at CMC.

Unique Identifier 139461107.2.1	Project Option 2.8.11	N/A	Sepsis Quality Initiative Apply Process Improvement Methodology to Improve Quality/Efficiency: Sepsis
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.1	Reference Number IT-4.8	Outcome Sepsis mortality (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
goal is to continue training and retraining staff as needed and to integrate the Sepsis Quality Initiative into all new staff orientations Data Source: Curriculum or other training schedules/materials Milestone 1 Estimated Incentive Payment: $1,649,785.50 **Milestone 2:** P-11 Number of trainings conducted by trainee/process improvement champions to new staff. <u>Metric 1:</u> P-11.1. Metric: Trained by the trainee/champion trainings a. Number of trainings conducted by designated process improvement trainees/champion b. Number of providers/staff trained by designated process improvement trainees/champion. Baseline/Goal: We have a designated Sepsis Coordinator as	Milestone 3 Estimated Incentive Payment: $1,199,885 **Milestone 4:** P-11 Number of trainings conducted by trainee/process improvement champions to current and new staff. <u>Metric 1:</u> P-11.1. Metric: Trained by the trainee/champion trainings a. Number of trainings conducted by designated process improvement trainees/champions. b. Number of providers/staff trained by designated process improvement trainees/champions. Baseline/Goal: : We have a designated Sepsis Coordinator as well as physician champions who will be holding monthly sessions for a total of 12 per year at CMC/CWC and1 each per year in Levelland and Plainview. Data source: Training program curriculum, educational materials, attendance lists, or other materials. Milestone 4 Estimated Incentive Payment	*Meaningful use of the Sepsis Resuscitation Bundle is defined as (unless there is a documented reason to deviate from the protocol): Within three hours of the recognition of severe sepsis or septic shock: 1) Measure lactate level 2) Obtain blood cultures prior to antibiotics 3) Administer broad-spectrum antibiotics 4) Administer 30ml/kg crystalloid for hypotension or lactate >=4mmol/L Milestone 6 Estimated Incentive Payment: $3,610,119	*Meaningful use of the Sepsis Resuscitation Bundle is defined as (unless there is a documented reason to deviate from the protocol): Within three hours of the recognition of severe sepsis or septic shock: 1) Measure lactate level 2) Obtain blood cultures prior to antibiotics 3) Administer broad-spectrum antibiotics 4) Administer 30ml/kg crystalloid for hypotension or lactate >=4mmol/L Milestone 7 Estimated Incentive Payment: $2,982,272

Unique Identifier 139461107.2.1	Project Option 2.8.11	N/A	Sepsis Quality Initiative Apply Process Improvement Methodology to Improve Quality/Efficiency: Sepsis
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.1	Reference Number IT-4.8	Outcome Sepsis mortality (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
well as physician champions who will be holding monthly sessions for a total of 12 per year at CMC/CWC and 1 each per year in Levelland and Plainview. Data source: Training program curriculum, educational materials, attendance lists, or other materials. Milestone 2 Estimated Incentive Payment (*maximum amount)*: $1,649,785.50	(*maximum amount)*: $1,199,885 **Milestone 5:** P-X. Milestone: Establish a baseline, in order to measure improvement over self. <u>Metric 1</u> P-X.1 Establish a 6-12 month baseline for patients with severe sepsis/septic shock where there is meaningful use of the Resuscitation Bundle a. Submission of baseline data Baseline/Goal: Initial review of charts revealed 575 cases in late 2011 to mid-2012. Data Source: Chart review of qualifying patients at CMC. Milestone 5 Estimated Incentive Payment (*maximum amount)*: $1,199,885		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,299,571	Year 3 Estimated Milestone Bundle Amount: $3,599,655	Year 4 Estimated Milestone Bundle Amount: $3,610,119	Year 5 Estimated Milestone Bundle Amount: $2,982,272
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $13,491,617			

Project Option: 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.2
Project Components: 2.9.1.a-e

- Provider: Covenant Medical Center, largest health system in the region, is a 622-bed hospital in Lubbock, Texas, serving a 64 county area and a population over 1,200,000.
- Intervention(s): The project will provide chronic disease self-management for 800 patients through a home-based Navigation program using individual interventions to remove obstacles and provide support which will decrease hospital admissions and prevent non-emergent ED visits. The navigation process is intensive is individualized to the educational and resource needs of each patient. The number of home visits performed for each patient ranges from 24-48 depending on the length of time the patient is navigated. The visits occur weekly for 1-2 months depending on the needs of the patient and then occur bi-weekly as the patient begins to achieve chronic disease management goals and increases their self-efficacy.
- Need for the project: Community needs assessment identified chronic disease management as a high priority in this region for patients with one or more chronic condition.
- Medicaid and Uninsured Target population: Of the Medicaid population in our region, approximately 16.4% of those have CHF, 10.40% have Type 2 Diabetes, 18.80% have Type I Diabetes, 26% have asthma and 3.8% have heart disease.
- Category 1 or 2 expected patient benefits: The project seeks to improve chronic disease management by providing individualized navigation services driven by behavior change which will result in healthier outcomes. With a potential referral base of 85,000 of patients with one or more chronic conditions in Lubbock County, we expect to enroll 400 patients by DY 3, 600 by DY 4 and 800 by DY5. We will also train 12 navigators over the 4 years of the waiver project. We will also train 12 navigators over the 4 years of the waiver project. Patients without PCP will increase from baseline of 77% to 85% in DY3, 90% in DY4 and 95% in DY5.
- Category 3 outcomes: IT-3.12 Our goal is to reduce diabetes 30 day readmission rates from baseline by DY5. Baseline for 30 day readmission was 259 for 2011 for Diabetes, Index 30 day readmissions was 103. Improvement target will be 45% in DY4 and 60% in DY5.

Project Option: 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.2
Project Components: 2.9.1.a-e

- **Project Description:** The goal of the Covenant Hospital Adult Navigator Program is to improve chronic disease self-management among Medicaid and the uninsured populations. Adults with chronic conditions such as Diabetes, heart disease and obesity, particularly those who are minority or middle to lower socio-economic status often encounter significant practice and health system barriers to accessing quality care. The Covenant Hospital Adult Navigator Program will provide individualized, cost-effective ways to reduce obstacles to care by providing social and medical support through a home visitation program. Navigators will provide educational support to patients through education about disease management, facilitate medication adherence, identify and facilitate resource procurement and improve communication between patients and their providers. With a potential referral base of 85,000 of patients with one or more chronic conditions in Lubbock County we expect to enroll 400 patients by DY 3, 600 by DY 4 and 800 by DY5. We will also train 12 navigators over the 4 years of the waiver project. Patients without PCP will increase from baseline of 77% to 85% in DY3, 90% in DY4 and 95% in DY5. Covenant plans to provide coordination of care, to improve patient outcomes evidenced by healthy clinical outcomes and to reduce inpatient hospital and ED readmissions.

  The navigation process is intensive is individualized to the educational and resource needs of each patient. The number of home visits performed for each patient ranges from 24-48 depending on the length of time the patient is navigated. The visits occur weekly for 1-2 months depending on the needs of the patient and then occur bi-weekly as the patient begins to achieve chronic disease management goals and increases their self-efficacy. The patient will then move to monthly visits for 2 months for maintenance and transition out of care coordination. The navigation team will consist of RN care coordinators working closely with patient navigators who will be recruited from a cadre of certified community health workers. This home visitation model will target at least 800 patients through referral from the ED inpatient case managers. Additionally, referrals are expected to come from local practitioners through an established referral system. The Covenant Hospital Adult Navigator Program will coordinate the care of the patients with diabetes, heart disease and obesity by working with them in a home setting using a behavioral change model. The navigator will work with the patients to identify and establish strong relationships with their PCPs. The navigator team will coordinate post-hospitalization and post-ED follow-up appointments with the PCP by making sure patients have transportation to the visit and will provide taxi or bus vouchers as needed. Navigators will assist uninsured patients to coordinate payment arrangements with PCPs and receive assistance in navigating through local federally qualified health centers when possible. The patient navigators are trained to deliver culturally appropriate education and resources. Making sure that the patient's hierarchy of

needs is met, they can focus on facilitating behavioral changes through motivational interviewing. Evidenced-based programs that provide assistance for patients with resource attainment and facilitate behavior change ultimately reduce hospital readmissions and ED utilization. The Covenant Hospital Adult Navigator Program model uses individualized interventions so the patient can achieve success in their disease management. These patients will be educated to recognize chronic disease triggers and taught how to manage those triggers properly. Patients will be able to differentiate when to go to the ED and when to make a PCP appointment by recognizing red flags for their individual disease process. Most importantly, these patients will receive education about medication adherence.

The Covenant Hospital Adult Navigator Program achieves the goals of RHP 12 by utilizing community health workers as patient navigators to provide enhanced social support and culturally competent care to vulnerable and high-risk population addressed in RHP 12 needs assessment CN.5. This program will act as a liaison between the health care providers and the patient, while diverting unnecessary ED visits, establishing PCP utilization and providing education that will prevent exacerbations.

- **Starting Point/Baseline:** Covenant Health Partners implemented (October 2012) a Navigator program specifically for a target population consisting of Covenant employees and their dependents. The model implemented through Covenant Health Partners is based on the results and the model tested by Texas Tech University Health Sciences Center, funded by Human Resources Services Administration. Covenant plans to expand this evidenced based navigation program to the Medicaid and uninsured population.

  The Covenant Hospital Adult Navigator Program expects to enroll a total of 800 patients by DY 5. Lubbock County has a population of 283,910 (2011 census.gov) with 24.2% of that population over the age of 65. Needs assessment data indicate that the prevalence of overweight and obesity among RHP residents is as high as 65.8% for men and 58.5% for women. 10.7% of individuals who reside in Lubbock County have diabetes, 7.8% have Coronary Artery Disease and account for 24% of Medicaid admissions for Covenant according to internal data base (Amalga) and 2010 Texas (Lubbock County) at www.countyhealthrankings.org. 11.6% have COPD with a higher incidence among Hispanics. Approximately $14.6 million is the cost for inpatient and ED treatment for patients cared for at Covenant with one of more of the target chronic conditions in 2011. There are approximately 181,849 individuals receiving Medicaid in our region, 6.4% of those have CHF, 10.40% have Type 2 Diabetes, 18.80% have Type I Diabetes, 26% have asthma and 3.8% have heart disease. These numbers provide us with f referral base of approximately 85,000 potential participants. We will establish a baseline from the referrals we receive from our ED and inpatient populations and grow the program from there.

- **Rationale:** This initiative was selected due to the results of the 2011 community health needs assessment conducted by Covenant which identified the need for chronic disease interventions for adult Medicaid and uninsured patients. The program at Texas Tech Health Sciences Center funded by HRSA demonstrated changes in clinical indicators targeted for each disease process, including systolic and diastolic blood pressure for hypertension; Hemoglobin A1c; for diabetes; results of lipid panels such as cholesterol,

triglycerides, low density (LDL) and high density (HDL) lipoproteins; and emergency visits/hospitalizations in asthma patients. Body mass index (BMI) and depression scores on the Personal Health Questionnaire (PHQ-9) were collected at intervals, along with multiple measures of behavioral indicators, such as Diabetes Self-Efficacy, Chronic Disease Self-Efficacy, Personal Resource Questionnaire, among others. The average HbA1c changed from 9.1 to 8.4, which was statistically significant. The average change in blood pressure was likewise statistically significant. Total Cholesterol, LDL, and HDL were slightly decreased. The paired *t*-test showed several major behavioral improvements through the navigation program. Compared with the baseline, the score for Self Efficacy of Chronic Disease Management and Diabetes Self Efficacy after navigation program were both significantly improved 1.07 ($p<.001$) and 1.13 ($p<.001$), respectively. All the subscales of Summary of Diabetes Self Activities form were significantly improved. Diabetes clients showed increased days per week for following a healthful diet plans ($M=0.68$, $SD=2.05$, $p<.05$), having five or more servings of fruits and vegetables per day but less high fat foods ($M=0.51$, $SD=1.78$, $p<0.05$), doing more exercise ($M=0.79$, $SD=2.34$, $p<0.05$), following doctors' recommendations on blood sugar testing ($M= 1.01$, $SD=2.81$, $p<0.05$), and checking the feet ($M=1.37$, $SD=2.61$, $p<.001$).(Esperat, M. C., Flores, D., McMurry, L., Feng, D., Song, H., Billings, L., Masten, Y., (May 31, 2012) "Transformacion Para Salud: A Patient Navigation Model for Chronic Disease Self-Management" *OJIN: The Online Journal of Issues in Nursing* Vol. 17, No. 2, Manuscript 2). We expect to achieve similar if not better results through the Covenant Hospital Adult Navigator Program.
A pilot program currently underway through Covenant Health Partners since November 2012 has saved approximately $30,514 in preventable ED visits for 21 patients with CHF and an additional savings of $67,212 of prevented hospitalizations for 15 patients with CHF and Pneumonia in this very short period of time.

The RHP 12 needs assessment CN.5 as noted above describes the need in our community for high-risk populations, and CN.4 also identified an urgent need to address obesity, diabetes and heart disease. Covenant has selected the projection option, 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others):

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

As noted above, baseline data will be used to identify the frequent ED users and through an effective referral system a navigation team will be deployed to provide culturally competent education and resources. The EMR can flag patients who have been to the ED and processes will be put in place to do a warm-hand off from the ED staff to the navigator program. In addition to recruitment from the ED, the inpatient case management team will refer patients being discharged from the hospital into the program through a warm hand-off system. Referrals are also expected from clinic providers (PCPs) who identify patients within their practice that meet

the established criteria for navigation services. Navigators recruited will be trained in cultural competency using the *Culturally and Linguistically Appropriate Standards (CLAS).*

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
A team approach will be used to deploy an innovative team who will provide the patient with a variety of tools needed to increase efficiencies and effectiveness of quality care throughout the different patient care settings. We expect to have an ED Case Worker to identify and to refer patients to a team of RN Care Coordinators and certified community health workers trained as navigators. These navigators will be recruited from a pool of locally certified community health workers trained in eight core competencies which include: advocacy, interpersonal skills, teaching skills, service coordination, organizational, communication, capacity building and knowledge base. Additional intermediate training will be provided upon hire to the whole team including RNs that will include motivational interviewing, chronic disease management, community resources, and data collection. This team will work closely with the ED providers, PCPs, ED Case Workers and the inpatient case managers to facilitate a smooth transition between services.

c) Connect patients to primary and preventive care.
The risk for increased ED utilization and hospitalizations lies in the lack of connection between chronic disease patients and their PCP. Many patients do not have PCPs and others that do, cannot access their services after hours. The Covenant Hospital Adult Navigator team will work as a liaison to establish a bridge between the patient and their PCP. If patients do not have an identified PCP, the team will assist with identifying a PCP and facilitate that relationship. Low health literacy is also found to be a culprit in poor disease management. The Navigator team will assess the patient's health literacy levels and provide appropriate educational resources. Red flags will be introduced to the patient and their families which will help them assess and decide when a patient should be taken to the ED or if there is a more appropriate and available source of care such as an appointment with their PCP. Most importantly, patients and their families will receive education regarding chronic disease triggers and how to avoid these triggers for better quality of life and health outcomes.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
Access to care management will be provided through a referral system within the ED as well as within the inpatient setting. Covenant expects to invite clinic providers to participate by referring patients for direct admission into the navigation program from their practice for patients among the target population that need education and resources. A team approach will exist throughout the inpatient setting to the outpatient home-based setting through the establishment of a warm handoff. The ED case worker and

the in-house case managers will provide care coordination while the patients are in the ED or hospital and the navigation program will extend those services to the home setting. This will provide a perfect continuum of care without fragmentation in services.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
A care registry will be used to capture care management documentation as well as disease outcomes. A robust quality management system will be implemented to capture trends, cost and savings. Interdisciplinary team meetings will take place on a monthly basis that will identify "lessons learned" and new strategies will be implemented to address opportunities for improvement. Medicaid and uninsured patients will be targeted for admission into the program. A program database will capture clinical outcomes such as changes in Hemoglobin A1c levels, LDLs, triglyceride levels, blood pressure readings, weight, BMI, and spirometry readings. Validated survey tools such as "Diabetes Self-Efficacy" and the "Chronic Disease Self-Efficacy" will assess changes in behavior pre and post navigation. The number and type of navigator encounters will be captured and documented in order to valuate time spent in the navigation process and cost savings achieved.

- **Related Category 3 Outcome Measure(s):**
  OD- 3 Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRS)
  IT-3.12 Other: Diabetes Risk-Adjusted 30 Day Readmission Rate *(Standalone measure)*
  Two pilot navigator projects have been conducted in the outpatient and inpatient setting at Covenant. The outpatient setting project, documented in the Online Journal of Issues in Nursing, proved to be successful in decreasing ED visits and hospitalization for patients with Asthma as well as biometric and behavioral changes for patients with Hypertension and Diabetes (Esperat, M. C.; Flores, D.; McMurry, L.; Feng, D.; Song, H.; Billings, L.; Masten, Y. [May 31, 2012] "Transformacion Para Salud: A Patient Navigation Model for Chronic Disease Self-Management" OJIN: the Online Journal of Issues in Nursing Vol. 17, No. 2, Manuscript 2.). The goal of the second pilot project with two local hospitals was to prevent 30 day readmissions and ED visits for patients without a designated Primary Care Provider and who were admitted with Hypertension, Diabetes, CHF, COPD or Asthma. This project, which is still in the pilot stage, has proven successful thus far with approximately 30 patients enrolled and only 1 inpatient readmission and 1 ED visit.
  By providing a new patient and family centric paradigm to facilitate behavioral change among patients with chronic conditions, we expect to improve the health outcomes of low-income populations. This program will serve as the bridge or liaison to a population of people which has proven to have problems navigating the health care system effectively and who also lack the resources to do so.

- **Relationship to other Projects:** This project supports and is related to the 127319504.2.1: Asthma Pediatric Navigation program (2.9) and complements that program since together they will address both the pediatric and adult at-risk populations. It also complements the 139461107.2.4: Covenant Palliative Care program (2.10) as the Covenant Health System seeks to provide increased access to outpatient care which supports the Triple Aim and transforms the way patients and providers seek and receive necessary care. All three transitional outreach programs seek to provide services beyond the walls of our hospitals and clinics in the community where the needs exist. Category 4 reporting domains for PPAs, PPRs, ED utilization and patient satisfaction will also be impacted by these increased activities in the outpatient setting.

- **Plan for Learning Collaborative:** Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the population in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:** RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines, the valuation considers that the Covenant Hospital Adult Navigator Program aims to expand the care beyond the walls of the hospital will assure the patients continue to receive high-quality, patient-centered care post-inpatient admission. Two patient navigation projects were piloted at Covenant Health System and University Medical Center. The pilot project was implemented to test the effectiveness of a navigation program in an in-patient setting and the effect of 30 day readmissions and ED visits for patients without a designated Primary Care Provider and who were admitted with Hypertension, Diabetes, CHF, COPD or Asthma. This project, which is still in the pilot stage, has proven successful thus far with approximately 30 patients enrolled from Covenant and only one patient had a readmission and another had an ED visit. University Medical Center observed similar successes.

  The Covenant Hospital Adult Navigator Program will create a new adult patient navigation program for a growing, high-cost Medicaid and uninsured target population of adults with chronic conditions. There will be cost avoidance for public payers as well as improved maneuvering through the ever-expanding continuum of care for adults as well as improved patient outcomes. Through the Covenant Hospital Adult Navigator program we expect to enroll over 800 patients by DY 5 (400 in DY 3, 600 in DY 4, 800 in DY 5). We will also train 12 navigators over the 4 years of the waiver project. Patients without PCP will increase from baseline of 77% to 85% in DY3, 90% in DY4 and 95% in DY5. Needs assessment data indicate that the prevalence of overweight and obesity among RHP residents is as high as 65.8% for men and 58.5% for women. 10.7% of individuals that reside just in Lubbock County alone have diabetes, 7.8% have Coronary Artery Disease and account for 24% of Medicaid admissions for Covenant. 11.6% have COPD with a

higher incidence among Hispanics. In 2011, the costs for inpatient and ED visits for these target conditions were approximately $14.6 million. There are approximately 181,849 individuals on Medicaid in our region. 6.4% of those have CHF, 10.40% have Type 2 Diabetes, 18.80% have Type I Diabetes, 26% have asthma and 3.8% have heart disease. These numbers provide us with a wide range of potential participants. As noted above, we will establish a baseline from the referrals we receive from our ED and inpatient departments and grow the program from there. We estimate the average cost for admission related to a chronic condition ranges from $2,000 to $6,000. Therefore, we expected there is significant cost savings potential to reduce more expensive claims related to readmissions to the ED and/or the inpatient setting.

Unique Identifier 139461107.2.2	Project Option 2.9.1	Project Components 2.9.1.a-e	Establish/Expand a Patient Care Navigation Program
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.2	Reference Number IT-3.12	Outcome OD- 3 Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRS) IT-3.12 Other: Diabetes Risk-Adjusted 30 Day Readmission Rate (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-2 Milestone: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. <u>Metric 1</u> P-2.1. Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline/Goal: We currently have 6 navigators trained in our pilot programs. We expect to train at least 12 over the next 4 years. Data Source: Workforce development plan for patient navigator recruitment, training and education Milestone 1 Estimated Incentive Payment (maximum amount): $2,887,125.00	**Milestone 2** P-3. Milestone: Provide care management/navigation services to targeted patients. <u>Metric 2</u> P-3.1 Metric: Increase in the number or percent of targeted patients enrolled in the program Numerator: Number of targeted patients enrolled in the program Denominator: Total number of targeted patients identified Baseline/Goal: This program is new for this target population so we will be identifying the total eligible as well as beginning to enroll patients. Our goal is to enroll 400 by DY 3. Data Source: Enrollment reports Milestone 2 Estimated Incentive Payment: $1,574,849 **Milestone 3** I-6. Milestone: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.	**Milestone 4** P-3. Milestone: Provide care management/navigation services to targeted patients. <u>Metric 4</u> P-3.1 Metric: Increase in the number or percent of targeted patients enrolled in the program Numerator: Number of targeted patients enrolled in the program Denominator: Total number of targeted patients identified Baseline/Goal: Enroll 600 by DY 4. Data Source: Enrollment reports Milestone 4 Estimated Incentive Payment: $1,579,427 **Milestone 5** I-6. Milestone: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. <u>Metric 5</u> I-6.4. Metric: Percent of patients without a primary care provider who are given a scheduled primary care	**Milestone 6** P-3. Milestone: Provide care management/navigation services to targeted patients. <u>Metric 6</u> P-3.1 Metric: Increase in the number or percent of targeted patients enrolled in the program Numerator: Number of targeted patients enrolled in the program Denominator: Total number of targeted patients identified Baseline/Goal: Enroll 800 patients by DY 5. Data Source: Enrollment reports Milestone 6 Estimated Incentive Payment: $1,304,744 **Milestone 7** I-6. Milestone: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. <u>Metric 7</u> I-6.4. Metric: Percent of patients without a primary care provider who

	Metric 3 I-6.4. Metric: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Baseline/Goal: 77% patients have PCP in DY1, will increase to 85% in DY3. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 3 Estimated Incentive Payment: $1,574,849	provider appointment Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Baseline/Goal: Increase the number of patients with primary care providers to 90% by DY 5. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 5 Estimated Incentive Payment: $1,579,427	are given a scheduled primary care provider appointment Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Baseline/Goal: Increase the number of patients with primary care providers to 95% by DY 5. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 7 Estimated Incentive Payment: $1,304,744
Year 2 Estimated Milestone Bundle Amount: $2,887,125	Year 3 Estimated Milestone Bundle Amount: $3,149,698	Year 4 Estimated Milestone Bundle Amount: $3,158,854	Year 5 Estimated Milestone Bundle Amount: $2,609,488
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $11,805,165			

Project Option: 2.17.1 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders.
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.3
Project Components: 2.17.1.a-g

- Provider: Covenant Medical Center, the largest health system in the region, is a 622-bed hospital in Lubbock, Texas, serving a 64 county area and a population over 1,200,000. Included is an adult, inpatient psychiatric unit that operates 32 beds, 16 of which are acute lock-down or secure rooms used for suicidal, homicidal or highly psychotic patients.
- Intervention(s): The project will provide transitional care services, such as medication management, life-skill coaching, follow-up appointment scheduling, and assistance with resources, for up to 300 patients who discharge from the inpatient psychiatric unit by DY5.
- Need for the project: Approximately 1,100 patients are discharged per year from the inpatient unit with 14% returning within 30 days for readmission and 30.48% who visit the ED post discharge for non-emergent reasons.
- Medicaid and Uninsured Target population: The overall target population of inpatient psychiatric patients includes Medicaid (17.9%) eligible as well as uninsured (30.5%).
- Category 1 or 2 expected patient benefits: The project seeks to provide transitional care services through an outpatient/transitional care clinic for patients with mental health disorders who are at high risk for readmissions. Patients will receive medication purchase assistance, housing and physical need coordination, and other services to improve transition back into the community. Covenant Transitional Outpatient Psychiatric Clinic will implement a mechanism to recruit 10% of patients in DY 3, from the unit who have a high risk for readmission and those coming through the ED and facilitate a warm hand off process. We will increase this warm hand off recruitment process to 30% in DY4 and 45% in DY5. a baseline of an average of 1100 inpatient encounters, we will target 70% of the high risk patients with a customized care plan before discharge in DY4 and 85% in DY5. A base line of 993 will be used to target 30% of patients discharged from inpatient unit and receive a follow up clinician phone in DY4 and 50% in DY5. In 2011, Covenant identified 392 Medicaid, 413 Medicare and 581 self pay encounters in the ED with a primary Psychiatric diagnosis. The average ED charges for these encounters were $3,387 per visit. The potential for savings in prevented ED Visits
- Category 3 outcomes: IT-10.1 Our goal is to increase the quality of life for patients who discharge from the in-patient psychiatric unit by providing transitional care through an outpatient clinic. The expense and hardship caused by repeated ED visits and readmissions coupled with the lack of community resources would drive the improvement of Quality of Life scores through the implementation of the Transitional Care Program. The Covenant Needs Assessment conducted in 2011 indicated a gap in medical interventions, prescription assistance and prescription management for uninsured and Medicaid mental health patients. In addition to these gaps the same needs assessment indicated that other MHMR services were not accepting new patients which leads to an increase in ED visits and hospitalizations. The multiple services offered by the Transitional Outpatient Clinic would fill some of these gaps and improve the Quality of Life for this population to 20% in DY4 and 40% by DY5.

Project Option: 2.17.1 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders.
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.3
Project Components: 2.17.1.a-g

- **Project Description:** Covenant Health operates an adult, inpatient psychiatric unit within a general hospital. The unit operates 32 beds, 16 of which are acute lock-down or secure rooms used for suicidal, homicidal or highly psychotic patients. The other 16 beds are in an intermediate unit which is unsecure. We treat patients with psychiatric mental illness and chemical dependency. The majority of the patients are admitted for a crisis stabilization situation. In FY 2012 the primary diagnosis was psychosis. The majority of admissions into the psychiatric unit come from the in-house emergency department. The Covenant ED serves as the region's hub for transfers that vary in level of complexity. We operate a 24-hour assessment team that initially assesses psychiatric and chemical dependency patients and then presents the ED cases to a psychiatrist for evaluation and treatment disposition. In the psychiatric unit we have a multidisciplinary treatment team comprised of Psychiatrists, Psychologist, Registered Nurses, Licensed Social Workers, Licensed Clinical Social Workers, Licensed Medical Social Workers and Licensed Chemical Dependency Counselors. Our unit is also the in-patient teaching arm of Texas Tech University Health Sciences Center for medical students and psychiatric residents. The unit serves as a psychiatric rotation for Covenant School of Nursing, South Plains College School of Nursing and Texas Tech University Health Sciences Center School of Nursing. We provide a rich teaching environment for social work interns from two local universities. One of the advantages of being a psychiatric unit within a hospital is the access to other physicians and subspecialties due the array of complex patients who are admitted with complex medical issues in addition to their mental disorder. We also take transfers from the region. Our inpatient units are the only psychiatric units located within a general hospital within 150 mile radius. There are only two other units in our region (150-200 miles from Lubbock) which include the Pavilion in Amarillo (90 beds) and Pampa Medical Center has a 13-bed geriatric unit.

  Covenant providers face significant challenges in providing appropriate, timely transitions for the unfunded patient when they are discharged from the inpatient setting to community outpatient providers. Many of these patients lack the resources for transportation to and from outpatient providers as well as the resources to purchase prescription medications. Covenant Health has chosen to address a gap in mental health care that is identified In RHP 12 needs assessment (CN.2), which is the lack of mental health services and inability to obtain an appointment with a provider.

  In order to address the challenges for providers, patients and the community, Covenant Health will open a robust outpatient clinic adjacent to the inpatient psychiatric unit staffed with Psychiatrists, Psychologists, Registered Nurses, Licensed Social Workers, Licensed Clinical Social Workers, Licensed Medical Social Workers and Licensed Chemical Dependency Counselors. The Covenant Transitional Outpatient Psychiatric Clinic will be a familiar setting located onsite where the patients will have a face-to-face encounter with psychiatric staff. This will be optimal for patients who are discharged from the Psychiatric Unit. Discharge planning will include a tour of the new

outpatient psychiatric clinic so the patient is familiar with where to return for appointments, a schedule of follow-up phone calls, and individualized care plans. In addition, the Covenant Transitional Outpatient Psychiatric Clinic will provide a source of outpatient medication management follow-up and assistance, life-skill coaching and assistance with resources and procurement.

In order to identify the patients who are in need of transitional services, we propose to determine the high-risk patients for readmission while they are in the inpatient unit through a risk analysis and provide transitional care services when they are dismissed from the unit. The transitional care services would include a visit by the mid-level Physician Assistant or Nurse Practitioner at the bedside to assess the patient while they are in the inpatient unit and to facilitate a warm hand off between the inpatient and outpatient staff. The PA or NP will then become the lead in a team of individuals who would become the patient's transitional care providers. In addition to an NP or PA, we have identified the use of a Licensed Chemical Dependency Counselor for diagnosis of substance abuse and mental health. Additionally, the outpatient team will provide medication resources and education to patients post-discharge as well as work through crises that may arise in order to prevent readmission and unnecessary ED utilization. Barriers identified when a patient is discharged from the unit include transportation and medication procurement. To alleviate these issues the social workers will provide cab or bus vouchers to these patients, and we will explore a medication voucher system similar to one that exists with a local pharmacy which will assist with medication adherence. We will provide access and coordination to community resources in the clinic setting where patients are comfortable and have 24 hour access to a crisis coach. A pilot project will determine the hours of operation and will allow for flexibility and make the changes necessary to accommodate the needs of the population served. The program will evolve as the patient's needs evolve.

By DY 5, the Covenant Transitional Outpatient Psychiatric Clinic will be established, and it will address the needs of the psychiatric patients through expansion of post-discharge services in an outpatient clinic setting. Not only will this program improve the quality of life for patients, but it will also improve potentially preventable readmission and potentially preventable ED visit rates.

- **Starting Point/Baseline:** On average, Covenant Health Inpatient Psychiatric Unit for behavioral health and chemical dependency, has approximately 1,100 admissions per year: 300-400 identified as Medicaid or uninsured with approximately 14% of them becoming 30-day readmissions. The number of patients that visited the ED with a primary psychiatric diagnosis during the same period was 1,622. 30.48% discharged from the ED with a primary psychiatric diagnosis were self-pay, 17.99% were Medicaid, and 21.03% were Medicare. The average daily census for the unit is 17. 14.33% (154) of admissions to the psychiatric unit were 30-day readmissions and an average of 1356 encounters of patients with a Psychiatric diagnosis occur in the ED per year. Covenant Transitional Outpatient Psychiatric Clinic will implement a mechanism to recruit 10% of patients in DY 3, from the unit who have a high risk for readmission and those coming through the ED and facilitate a warm hand off process. We will increase this warm hand off recruitment process to 30% in DY4 and 45% in DY5. From a baseline of an average of 1100 inpatient encounters, we will target 70% of the high risk patients with a customized care plan before discharge in DY4 and 85% in DY5. A base line of 993 will be used to target 30% of patients discharged from inpatient unit and receive a follow up clinician phone in DY4 and 50% in DY5. In 2011, Covenant identified 392 Medicaid, 413 Medicare and 581 self pay encounters in the ED with a primary Psyc diagnosis. The average ED charges for these encounters was $3,387 per visit. The potential for savings in prevented ED Visits. The DRG codes most frequently identified for the 30 day readmission included, 291.81 (Alcohol Withdrawal) with

secondary DRGs of 270.6, 289.81, 296.54 and 572.3. Other DRGs included 292 (Drug Withdrawal), 295.3 (Paranoid Schizo-Unspec), 295.7 (Schizoaffective disorder, unspecified) and 296.43 (Bipolar).

- **Rationale:** One of the major gaps in the transition of care is the lack of availability of timely medication management appointments with a psychiatrist or mid-level and an assigned Psychiatrist for continuity of care. The Covenant Transitional Outpatient Psychiatric Clinic was selected to bridge that gap. The results of the 2011 community needs assessment conducted by Covenant identified overutilization of the ED for mental/substance abuse issues and confirmed that this program is on the right path to meet the needs of the community. The needs assessment identified that for the 2009 census data, 18.8% of the adult population experience 5 or more poor mental health days. Another community needs assessment conducted by a local federally qualified health center, Community Health Center of Lubbock, identified procurement of medications as a barrier as well as a gap in services provided. The RHP 12 needs assessment, CN.2, identified 6% of the population in our region to have a mental health disorder present. We believe this program will impact 30-day readmission for the patient with an actual episode of care need versus those with habitual admissions that seek hospitalizations for housing or other medical needs.

  We believe our community will benefit most from the proposed initiative as identified in the needs assessment not only because it will benefit the population of focus but because our providers face a significant challenge in providing appropriate, timely transitions for the uninsured patients when they are discharged from the inpatient setting to community outpatient providers. Many of these patients also lack the resources for transportation to and from outpatient providers as well as the resources to purchase prescription medications. They also lack skills and knowledge in the coordination of outpatient care and resources. Incorporating the required core components identified below, we propose to implement specific pilot initiatives that would lead to a robust transitional care project. As noted in the table below, milestones include establishing a tool to identify these patients and establishing warm hand offs which will better insure continuity of care.

  Project option 2.17 Establish improvements in care transition from the inpatient setting for individuals with mental health and/or substance abuse disorders was selected as the most appropriate for this project. Below we have identified utilization of core components, which also reflect the tools, trainings and warm handoffs in our milestones and metrics.

  Required core project components:

  a) The Covenant Health Psychiatric Unit Transitional Care team will consist of an NP or PA, a Licensed Chemical Dependency Counselor and social workers under the supervision of a Psychiatrist.

  As noted above the team, the NP and PA, will begin care while the patient is still in the inpatient unit. This will establish relationships and further increase the team's ability to respond to and to prepare for the patient in the outpatient clinic. We expect the team to include an LCDC for diagnosis of substance abuse and mental health. Social workers will be included to integrate community resources and representatives from community agencies that could directly impact community services and resources such as the Salvation Army, Community Health Center of Lubbock Homeless Coordinator, transportation representative and other members that could be added as additional needs are identified will be invited to join as well.

b) Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient and provider interviews.
A new EMR system in the ED will assist in developing chart review tools to identify users who are identified as high risk for ED readmissions. Covenant has a database which can be used to pull diagnosis codes, readmission rates and other factors identified as key drivers. Covenant will also implement a robust survey process that will assess patient and provider satisfaction with the proposed project.

c) Identify baseline mental health and substance abuse conditions at high risk for readmissions, (example include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency).
Current databases will be used to identify baseline measures. A report will be created and sent to the Covenant Transitional Outpatient Psychiatric Clinic director which would identify patients at risk for readmission. This will be used by hospital personnel to identify patients for referral into the Covenant Transitional Outpatient Psychiatric Clinic team.

d) Review best practices for improving care transitions from a range of evidence-based or evidence-informed models.
This project proposes to use effective components identified in evidenced models on the SAMHSA website that include the Wellness Recovery Action Plan (WRAP) and Critical Time Intervention (CTI). The WRAP program is an intervention for adults with mental illness which assist individuals in developing life goals and teaches them to use the resources identified towards recovery. This program's interventions are based in a group setting whereas the Covenant Transitional Outpatient Psychiatric Clinic will be individualized. The CTI program is designed to assist homeless individuals navigate mental illness services by providing post discharge services such as transition guidance into the community and crisis support. CTI uses a home-based model whereas our program will not be doing home visits. Both of these projects use an outpatient intervention mechanism that includes the idea of life skills coaching with transition back into the community. Integrated care models are strongly advocated by SAMHSA, and we have also researched and plan to adapt concepts such as "person-centered care" and "data-driven care."

e) Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=208 (NREPP, SAMHSA's National Registry of Evidence-based Programs and Practices "Wellness Recovery Action Plan, WRAP"
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=125 NREPP, SAMHSA's National Registry of Evidence-based Programs and Practices "Critical Time Intervention, CTI"
http://www.integration.samhsa.gov/clinicalpractice/CIHS_Health_Homes_Core_Clinical_Features.pdf "Behavioral health outcomes for people with mental and substance use conditions"

f) Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. One of the pilot interventions that will be implemented will be the risk assessment tool that will identify patients at high risk for readmission. The ED case worker will then refer patients into the Covenant Transitional Outpatient Psychiatric Clinic for outreach. Data will be collected to capture reduced potentially preventable ED utilization. The second pilot project will consist of post discharge medication planning. Covenant Transitional Outpatient Psychiatric Clinic team will provide resources for medication such a vouchers and transportation to pick up medications. Covenant currently has a fund that provides free medications through a voucher program through a local pharmacy, and this can be expanded to include psychiatric medications.

g) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
The director for the Covenant Transitional Outpatient Psychiatric Clinic is LEAN-certified and those LEAN methodologies will be implemented to conduct quality improvement methods which will identify impact and areas for improvement. In addition data gathered and lessons learned from the pilot projects will provide opportunities for improvement. We believe the project can be expanded to larger settings and replicated in different areas that serve similar populations.

- **Related Category 3 Outcome Measure(s)**
  OD-10 Quality of Life/Functional Status
  IT-10.1 Quality of life

  Average ED charges for ED utilization for patients with a behavioral health primary diagnosis is $3,148, and there were a total of 1,129 ED visits in 2012 for this population. Given this information, this project will improve transition processes that are now fragmented and develop effective mechanism to improve patient health outcomes and quality of life/functional status post discharge.

  By incorporating evidenced-based elements from projects such as WRAP, CTI and SAMHSA endorsed project interventions, this project will demonstrate improvement in the quality of life. The underserved populations of our region are the most vulnerable to the gaps in services. Their lack of resources, some as simple as transportation, make it difficult for them to navigate through the mental health care arena. This project will focus on serving that population, beginning with discharge from the psychiatric unit when they are the most vulnerable to relapse. Providing outreach services post discharge of the unit and post visit to the ED will improve these patients' quality of life. This will be assessed using a validated instrument prior to discharge and at appropriate intervals.

- **Relationship to other Projects**: Covenant Transitional Outpatient Psychiatric Clinic will reinforce the interventions submitted within the RHP by expanding care outside the walls of the hospital setting through the outreach program that will decrease cost, improve patient outcomes, and improve quality of care. This project 2.17 is related to project 127319504.2.1: Asthma Pediatric Navigation program (2.9), 139461107.2.2: Covenant Hospital Adult Navigator Program (2.9), and 139461107.2.4: Covenant Palliative Care program (2.10) because

they all implement a transitional process for specific populations which, according to the needs assessment, are the most vulnerable to receiving fragmented care. Although similar, each project uses evidence-based interventions for their population of focus. The project has direct relation with Category 4 by impacting potentially preventable admission and readmission rates related to behavioral health and substance abuse under OD-2 and OD-3.

- **Plan for Learning Collaborative:** A collaborative coalition will be implemented to include Texas Tech University Health Sciences Center and the Community Health Center of Lubbock. This coalition will meet quarterly to generate new ideas, share data and identify additional innovative ways to meet the needs of the community. Since Covenant Psychiatric Unit is the learning hub for medical, nursing, and social work students, this collaboration can work to create curriculums that include transitional care processes. Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the population in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation**: RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines, the valuation considers that the Covenant Transitional Outpatient Psychiatric Clinic's aim to expand care beyond the walls of the hospital will ensure that patients continue to receive high-quality, patient-centered care post- inpatient admission and beyond their ED visits. The outpatient services provided will improve the healthcare infrastructure by expanding access and capacity for needed behavioral healthcare in the community where the Medicaid and uninsured patients reside. This program will provide a seamless care delivery model with warm handoffs along the way. Transformation includes the optimal use of health care dollars. Average ED charges for ED utilization for patients with a behavioral health primary diagnosis is approximately $3,148, and a total of 1,129 ED visits for 2012 for this population. This cost-effective program expects to save Medicaid and uncompensated care expenses by preventing readmissions and decreasing inappropriate ED utilization according to HEALTHCARE.org: "Better Care Transitions and Fewer Readmissions." The proposed project invests in significant improvements and expansions for transitional and coordinated care for high risk individuals with mental health and substance abuse disorders. The transitional care team expands the capacity of providers and staff including Psychiatrists, Psychologists, NPs/ PAs, Licensed Chemical Dependency Counselors and social workers. We have identified claims and estimate the transitional care program to potentially impact 30.27% of uninsured, 16.15% of Medicaid and 23.10% of Medicare patients. The Covenant Transitional Outpatient Psychiatric Clinic is one way RHP 12 addresses the critical need for access to more intensive care transition services.

Unique Identifier 139461107.2.3	Project Option 2.17.1	Project Components 2.17.1.a-g	Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.3	Reference Number IT-10.1	Outcome OD-10 Quality of Life/Functional Status IT-10.1 Quality of life

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-28 Gap analysis regarding patient communication with doctors, nurses, and/or discharge information. <u>Metric 1</u> P-28.1 Metric: Gap analysis complete Baseline/Goal: No gap analysis currently exists for program but one will be completed by 9/30/2013. Data Source: Documentation of analysis. Milestone 1 Estimated Incentive Payment: $1,856,008.50 **Milestone 2** P-5 Develop an assessment tool to identify patients who are at high risk for readmission. <u>Metric 1</u> P-5.1 Multidisciplinary committee approves assessment tool	**Milestone 3** P-3 Identify baseline high-risk patients analyzing Diagnoses, Diagnostic-related Groups (DRGs) and /or other data elements regarding 30-day readmissions for acute care and home care patients. <u>Metric 1</u> P-3.1 Metric: Documentation of position of chart review a. Documentation of chart review Report Baseline/Goal: 35% or at least 70 charts will be reviewed and documented by 9/30/2014. Data Source: Randomized chart review. Milestone 3 Estimated Incentive Payment: $1,349,870.67 **Milestone 4** P-15 Educate appropriate clinical staff on key contributing factors to	**Milestone 6** I-31 Warm Hand offs <u>Metric 1</u> I-31.1 Percent increase of the use warm handoffs (a clinician to clinician real time live communication) for adult inpatients being discharged to the community a. Numerator: Number of individuals in target population transitioned from adult inpatient units into community behavioral health programs via a warm handoff. b. Denominator: Number of individuals in target population transitioned from adult inpatient units into community behavioral health programs Baseline/Goal: We expect to increase the utilization of warm hand offs to 30% in DY4 Data Source: Report on percentage of adult transfers to alternative care settings during which warm handoff	**Milestone 9** I-31 Warm Hand offs <u>Metric 1</u> I-31.1 Percent increase of the use warm handoffs (a clinician to clinician real time live communication) for adult inpatients being discharged to the community a. Numerator: Number of individuals in target population transitioned from adult inpatient units into community behavioral health programs via a warm handoff. b. Denominator: Number of individuals in target population transitioned from adult inpatient units into community behavioral health programs Baseline/Goal: We expect to increase the utilization of warm hand offs to 45% in DY4 Data Source: Report on percentage of adult transfers to alternative care settings during which warm handoff

Unique Identifier 139461107.2.3	Project Option 2.17.1	Project Components 2.17.1.a-g	Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.3	Reference Number IT-10.1	Outcome OD-10 Quality of Life/Functional Status IT-10.1 Quality of life

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Baseline/Goal: We will establish a multidisciplinary committee that will hold monthly meetings. Data Source: Approved sample tool and meeting records. Milestone 2 Estimated Incentive Payment: $1,856,008.50	preventable readmissions. <u>Metric 1</u> P-15.1 Percent of key clinical staff completing educational sessions a. Identify staff and training dates Baseline/Goal: 100% of current and new staff will receive educational sessions. Data Source: Internal hospital records/documentation; Training curricula Milestone 4 Estimated Incentive Payment: $1,349,870.67 **Milestone 5** I-31 Warm Hand offs <u>Metric 1</u> I-31.1 Percent increase of the use of warm handoffs (a clinician to clinician real time live communication) for adult inpatients being discharged to the community	occurred Milestone 6 Estimated Incentive Payment: $1,353,794.67 **Milestone 7** I-37 Improvement in percentage of "High Risk" patients with customized care plans before discharge <u>Metric 1</u> I-37.1 Percent improvement in percentage of "High Risk" patients with customized care plans before discharge a. Numerator: Number of patients identified as "high risk" patients with customized care plans before discharge b. Denominator: Number of discharged patients identified as "high risk" patients Baseline/Goal: We will establish a baseline of the high risk patients out of the 1100 inpatient encounters and target 70% of those encounters	occurred Milestone 9 Estimated Incentive Payment: $1,118,352.00 **Milestone 10** I-37 Improvement in percentage of "High Risk" patients with customized care plans before discharge <u>Metric 1</u> I-37.1 Percent improvement in percentage of "High Risk" patients with customized care plans before discharge c. Numerator: Number of patients identified as "high risk" patients with customized care plans before discharge d. Denominator: Number of discharged patients identified as "high risk" patients Baseline/Goal: We expect to increase the use of customized care plans to 85% Data Source: Report on "High Risk"

Unique Identifier 139461107.2.3	Project Option 2.17.1	Project Components 2.17.1.a-g	Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.3	Reference Number IT-10.1	Outcome OD-10 Quality of Life/Functional Status IT-10.1 Quality of life

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	a. Numerator: Number of individuals in target population transitioned from adult inpatient units into community behavioral health programs via a warm handoff. b. Denominator: Number of individuals in target population transitioned from adult inpatient units into community behavioral health programs Baseline/Goal: Baseline of 154 inpatient 30 day readmissions and 1356 ED Pysch encounters/Goal to recruit 10% of potential patients Data Source: Report on percentage of adult transfers to alternative care settings during which warm handoff occurred Milestone 5 Estimated Incentive Payment: $1,349,870.67	Data Source: Report on "High Risk" patients with customized care plan before discharge Milestone 7 Estimated Incentive Payment: $1,353,794.67 **Milestone 8** 1-40 Assessment and follow up <u>Metric 1</u> I-40.1 X% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance. a. Numerator: The number of patients in the target population discharged from inpatient settings who have received follow-up contact (two attempts) to review treatment plans and assess compliance. b. Denominator: The number of patients in the target population discharged from inpatient settings Baseline/Goal: Baseline of1100 and	patients with customized care plan before discharge Milestone 10 Estimated Incentive Payment: $1,118,352.00 **Milestone 11** 1-40 Assessment and follow up <u>Metric 1</u> I-40.1 X% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance. a. Numerator: The number of patients in the target population discharged from inpatient settings who have received follow-up contact (two attempts) to review treatment plans and assess compliance. b. Denominator: The number of patients in the target population discharged from inpatient settings Baseline/Goal: We expect totarget 50%

Unique Identifier 139461107.2.3	Project Option 2.17.1	Project Components 2.17.1.a-g	Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.3	Reference Number IT-10.1	Outcome OD-10 Quality of Life/Functional Status IT-10.1 Quality of life

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
		target 30% Data Source: Medical Records; Project Data, Clinician Logs Milestone 8 Estimated Incentive Payment: $1,353,794.67	Data Source: Medical Records; Project Data, Clinician Logs Milestone 11 Estimated Incentive Payment: $1,118,352.00
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,712,017	Year 3 Estimated Milestone Bundle Amount: $4,049,612	Year 4 Estimated Milestone Bundle Amount: $4,061,384	Year 5 Estimated Milestone Bundle Amount: $3,355,056
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $15,178,069			

Project Option: 2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.4
Project Components: 2.10.1.a-d

- Provider: Covenant Medical Center, largest health system in the region, is a 622-bed hospital in Lubbock, Texas, serving a 64 county area and a population over 1,200,000.
- Intervention(s): The project will provide outpatient palliative care services to at least 300 patients.
- Need for the project: The Covenant Inpatient Palliative Care Unit's yearly census ranges from 500-600. We propose that the three major areas of concentration for outpatient services would include Oncology, Pulmonology with a focus on COPD and Emphysema, and Cardiology with a focus on CHF. These will decrease ED utilization for end stage diagnosis as well as 30-day stays in the ICU.
- Medicaid and Uninsured Target population: Open access appointments for patients discharged from the inpatient unit as well as any referrals from the ED will allow for access to the provider for medication management. The target population will include Medicaid (19.5%) eligible as well as uninsured (6%).
- Category 1 or 2 expected patient benefits: The project seeks to provide outreach services through a clinic setting for medication management, appropriate treatment options for end-stage chronic conditions, decision making resources and spiritual care for patients transitioning from the inpatient palliative unit. We expect to provide consults to 150 patients in DY 3, 225 patients in DY 4 and 300 in DY 5. These consults will include counseling to seriously ill patients with an interdisciplinary approach regarding life expectancy, sickness, pain, treatment, social and spiritual care, and patient and family preferences. We expect 175 patients in DY 3 and 220 patients in DY 4 to discharge to home care, hospice or a SNF. Additionally, we expect to increase the number of patients who die in our facility and receive palliative care consults.
- Category 3 outcomes:
    - IT-13.1 Our goal is to increase the percentage of patients who receive a comprehensive clinical assessment to determine the severity, etiology and impact of their pain from baseline to 90% compliance in DY4 and 95% compliance in DY5.
    - IT-13.2 Our goal is to increase the percentage of patients with documentation of treatment preferences from baseline to 90% in DY4 and 95% in DY 5.
    - IT-13.5 Our goal is to increase the percentage of patients receiving hospice or palliative care with discussion of spiritual/religious concerns documented in their clinical records from a baseline to a target of 90% in DY4 and 95% in DY5.

Project Option: 2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider: Covenant Medical Center/139461107
Unique Identification Number: 139461107.2.4
Project Components: 2.10.1.a-d

- **Project Description: C**ovenant Health currently has a 17-bed inpatient palliative medicine unit and a consult-based program to support in-patients with life threatening, life-limiting chronic diseases. Since its inception in 2006, the program has grown between 130%-153% each year. The unit has been recognized as a best practice unit in the Health System and in the community. Our palliative medicine program provides goals for acute care, aids for meeting those goals, pain management experts, education and emotional support tools for patients and their families.

  The current need is for a complementary outpatient, community-based palliative medicine clinic to support patients with life-limiting chronic diseases that need supportive care, goals of life care planning and advanced symptom management. The Covenant Outpatient Palliative Clinic will establish an outreach clinic staffed with a physician, a mid-level, a nurse and a social worker. One community needs assessment identified that two of the top three needs for adult/geriatric population are assistance with chronic diseases and medication management. RHP 12 (CN.1) also identifies a shortage of physicians in this specialization. The target population will be patients recruited from the inpatient palliative unit with a concentration on referrals from Oncology; Pulmonology with a focus on COPD and Emphysema; and Cardiology with a focus on CHF. This team will provide medical care as well as advanced symptom management services. In addition, the social worker will be available to offer patients health care choices that would include goals of life care planning and advance- directives. Additionally, spiritual support will be provided through a referral system to appropriate clergy members.

  Patients with cancer or any life-threatening disease face a broad array of physical, spiritual, emotional, and financial problems. “Palliative care has a body of knowledge that can help patients, families, and even the primary care physicians treating those patients cope with problems related to debilitating chronic disease,” said Eduardo Bruera, M.D., a professor in and chair of the Department of Palliative Care and Rehabilitation Medicine at The University of Texas MD Anderson Cancer Center. The Covenant Outpatient Palliative Clinic will focus on reducing physical, spiritual, emotional and financial problems faced by the population by addressing the individual as a collective philosophy, not just as a medical issue.

  An example of how Palliative Care program can make an impact on patients with terminal diagnosis is that Lubbock county and the five surrounding service area sees 1,107 new cancer diagnosis each year and 593 cancer related deaths. The most recent studies show that cancer patients spend an average of $70,000 per diagnosis to treat cancers – regardless of prognostic outcome.

  A study of 151 patients published last summer in *The New England Journal of Medicine* showed that getting early palliative care — in addition to regular medical treatment — helped people with lung cancer live three months longer, compared with those

given standard care. Additionally, participants indicated a greater quality of life with lessened emotional, mental and financial burdens. Palliative medicine programs have demonstrated reduced costs, increased support to families facing a life-limiting diagnosis.

The same service area sees (Lubbock and surround 4 counties) more than 838 deaths each year from cardiovascular diseases and 194 deaths related to chronic lower respiratory disease. Berger, O'Riordan, et al. demonstrated that outpatient palliative medicine programs established in California were able to reduce the burden on patients, families and support systems significantly, while supporting and enhancing quality of life.

Internal tracking shows that 24.69% (58 patients in the last six months) of patients serviced by our palliative medicine inpatient program have been in the hospital in the previous 30 days for the same diagnosis. Patients with chronic and life-limiting diseases are referred to the program an average of six days into their hospitalization and 74.69% of these patients end up dying in the hospital. Extracting the data, roughly 89% of the patients would have benefited from outpatient palliative medicine and would have decreased hospitalizations by 53%.

Greer J, McMahon P, Tramontano A, et al. *J Clin Oncol.* 2012;30 (suppl; abstr 6004) demonstrated in their work that patients in outpatient palliative medicine had associated costs lowered by $2,282 (per hospitalization)hese cost savings were found through decreased treatment costs, such as chemotherapy, and hospitalizations and timelier referral and resource allocation to hospice. Patients and families reported a greater sense of care and better understanding of their disease process.

13.7% of those in the service area(Lubbock and surround 4 counties)provided insurance coverage under the Medicare benefit and 23.2% report not having insurance. Covenant Health is a leading provider in health care and annually provides care to patients without health care insurance (6% of its patient mix).

The three major diagnosis that contribute to the mortality rate in Lubbock county and surrounding counties are cardiovascular disease, cancer and chronic lower respiratory diseases. Each year, more than 1,625 patients die from these combined diseases or 222 Medicare patients and 377 unfunded patients – with the majority seeking services from Covenant Health or one of its entities. If only 50% of these patients were offered palliative medicine, the costs savings could be $1.854 million each year. This does not include patients of other diagnoses who could benefit from palliative medicine during treatment or in the last year of their lives.

In DY 3, we will provide services to 150 of patients, in DY 4 - 225 of patient and by DY 5, Covenant will establish the Covenant Outpatient Palliative Clinic, an outpatient program which will offer counseling to seriously ill patients with an interdisciplinary approach regarding life expectancy, sickness, pain, treatment, social and spiritual care, and patient and family preferences to 300 patients.

- **Starting Point/Baseline:** Currently the inpatient Palliative Care unit yearly census ranges from 500-600 encounters with 406 encounters directly from the inpatient unit and the rest from consults from other units. 45-50% of patients in the unit are at their end-of-life stage so the remaining 50% (250-300) would qualify for the proposed outpatient services. In order to decrease ED utilization for end-stage diagnosis as well as last 30-day stays in ICU, we propose that the three major areas of concentration for outpatient services would include Oncology, Pulmonology with a focus on COPD and Emphysema, and Cardiology with a focus on CHF. An average of 26.9 patients with heart failure and 22.6 patients with COPD have 30-day hospital readmissions according to an article by Jencks et al, 2009. (Jencks, S.; Williams, V.; Coleman, E. NEJM 2009; 360:1418-1428, April 2, 2009 "Re-hospitalizations among patients in the Medicare Fee for Service program"). Information from our internal data base (AMALGA) from 10/01/2011 to 10/01/2012 indicated that ICU admissions (last 30 days) for CHF increased from 62 (2011) to 238(2012), for Cancer from 19(2011) to 56 (2012) and for COPD from 11 (2011) to 52 (2012). In addition there were 422 ED encounters for the primary diagnosis of Cancer, COPD and CHF between 10/01/2011 and 10/01/2012. The Covenant Palliative Unit had 406 encounters during the period of 10/01/2011 and 10/01/2012 with a 22.66% readmission rate. Our program expects to improve potentially preventable readmission and ED visit rates and reduce ICU visits in the last 30 days of life though these are not our related outcome measure in Category 3. In category 3 we will report outcome improvements in pain assessment, treatment preferences and spiritual/religious discussions. Our goal is to provide outpatient palliative care services for 300 patients by DY 5.

- **Rationale:** Patients with life-limiting or life-threatening diseases or conditions often suffer from significant pain, often unrecognized or ineffectively treated by practitioners. Additionally, this population often must make difficult decisions on treatment options-especially around life sustainment-either immediately or within the near future. Palliative medicine practitioners offer a unique skill-set in both pain management and in developing goals of care and plans of care for these patients. RHP 12 (CN.1) also identifies a shortage of physicians in this specialization. Spiritual concerns and religious beliefs will also be part of the outpatient intervention in order that the patient and their families feel support in the difficult decisions that they face. Ultimately these conversations and decisions will lead to better patient care, patient/family satisfaction and better utilization of resources.

  The Journal of the American Medical Association (199;281[2];163-168) identified that patients in palliative care programs need the following: pain and symptom control, no inappropriate prolongation of the dying process, a sense of control; less burdens for the family, and a strong relationship with family. The Covenant Outpatient Palliative Clinic can support the complex needs of the patient and their caregivers in a clinical setting. With medication changes that occur post discharge, patients tend to be readmitted due to poor medication adherence issues, mostly because they are unable to access a provider to address these issues. Through this project option 2.10 Use of Palliative Care Programs, we will increase access and availability of outpatient palliative care, which will significantly expand our current palliative care program.

Required core project components:

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program.

The Covenant Outpatient Palliative Clinic care will offer continuity of care from the inpatient to outpatient setting which benefits the patient as well as the clinicians. The earlier a patient is involved in their own disease management, the greater improvement seen in their clinical outcomes. Outpatient services are a proactive rather than a reactive approach to crisis management which may arise due to low health literacy, poor medication management and inadequate pain control. Family members and caregivers will be equipped by the social workers to assist their loved ones make difficult decision about their condition and both patient and family members are taught coping skills. Support staff such as clergy will be available to address spiritual care and religious concerns. Collaborations between in-patient providers and outpatient providers will avert hospital readmissions and unnecessary visits to the ED, and decrease ICU 30 last day admissions. Planning activities will take place during year 2 with deployment of the services in year 3. The outreach clinic will be staffed with a physician, a mid-level, a nurse and a social worker who will provide a continuum of services. Open access appointments for patients discharged from the inpatient unit as well as any referrals from the ED will allow for access to the provider for medication management. Patient and family interactions with the social worker will increase the number of patients that have documented end of life records such as advance directives. These processes will prevent costly ICU stays and emotionally draining decisions for the family. Transitional services from the inpatient to the outreach clinic will be feasible due to the proximity of the clinic to the inpatient unit. This proximity will also allow for coordination of services between the providers. Currently there are two providers in the community trained in Palliative Medicine with a host of Palliative Fellows, usually 2 per year that rotate through the clinic.

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility.

Evidence shows that at least one-third of the patients discharged from an acute care setting lack post-discharge follow-up arrangements, while less than half of the their PCPs have knowledge of the changes in medication that took place during hospitalization. In addition, as low as 3% of the PCPs are involved in the post-discharge discussions, and most providers are not even notified of their patient's hospitalization. Referrals to outpatient Palliative care outreach services from the in-patient units will reduce these inefficiencies. The transition process will be best facilitated due to the proximity of the inpatient unit to the outpatient clinic for easy communication with both inpatient and outpatient staff. Additionally this will complement discharge services for patients discharging into home care, hospice or SNFs.

c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time.

The project will adapt the FAMCAR patient satisfaction survey which is a 20-item tool that measures patient satisfaction with availability of care as well as psychosocial care. In addition Covenant tracks HCAHPS scores very closely and recommends changes to the different medical units accordingly. The Edmonton Symptom Assessment Form (ESAF) assesses the patient's pain, tiredness, nausea, depression, anxiety, drowsiness, appetite and well-being. This assessment will be incorporated as part of the clinic visit to assess effective symptom management and can be tracked with documented changes in a database created for reporting purposes.

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
Quality improvement process will be identified and established in year 2. Rapid cycle assessment of outpatient clinic referrals and appointments will be implemented to assure proper access and timely appointments. Data will be maintained of ESAF scores for effective symptom management and FAMCAR patient satisfactions scores will be monitored for possible "lessons learned" and opportunities for improvement in processes of care. Hospital admission and ED utilization data will be monitored for patients seen through the Covenant Outpatient Palliative Clinic. Emphasis in decreasing LOS and 30 last days admits in intensive care units will also be captured through an internal data system. Charts will be audited for documentation regarding spiritual care and life care planning documents such as advance directives. Ongoing assessment of program effectiveness will be established to ensure the target population's needs are met for outpatient palliative care.

The project addresses the CN.1 in RHP needs assessment due to the lack of providers in the region and the shortage of providers with expertise in palliative care. In one local community needs assessment, the top three needs identified for the adult/geriatric population included medications and chronic disease management. It is evident that there is a gap in care with hospital readmissions for patients with chronic conditions (438 admissions to the ICU for CHF, COPD and Cancer from 10/01/2011 through 10/01/2012 and 422 encounter through the ED for the same diagnosis and the same time period) and thus the need for individuals that could benefit from palliative care exist. Proper medication adherence and inability to manage pain are among the reasons for the 15-20% of readmission rates in the palliative unit; therefore, measures will be put into place to track these changes as patients are referred to outpatient palliative care services.

Challenges:

Many challenges exist in palliative medicine as a collective field of medicine. Chief among these obstacles is awareness, as noted by Dr. Edurado Burera in a recent article. As a new and burgeoning field, there is still a lack of awareness by specialists on the

benefits to patients, administrators being unsure of the benefits to allocate dollars to the program and a general unawareness by patients on palliative medicine, especially in how is differs from hospice care. Lastly, there are often questions about boundaries between traditional specialists and their role versus the role of palliative medicine. This challenge can be overcome through aggressive and directed education to key stake holders.

Trained palliative medicine physicians can be difficult to recruit to support new programs. There are few training programs and even fewer boarded physicians, especially those who have worked in outpatient palliative medicine clinics. Covenant Health is working with Texas Tech School of Medicine it training palliative medicine fellows, but retention of the fellows will be difficult because of the number of positions that are open for boarded physicians on a national level.

Staffing in general can be a challenge. Growth of programs, like their inpatient counterparts, tend to take on an exponential growth patterns rather than a linear pattern. This means a "feast or fathom" atmosphere develops and creates pressure on adding staffing in a pattern that makes sense from a business perspective. Staff also has to be prepared for compassion burnout and adding new skill sets based on a changing patient population, which can be difficult and frustrating.

The Advisory Board noted it is recent presentation that outpatient palliative medicine is being approached by a different models and evidence has not demonstrated the most effective model – dedicated clinical space, embedded clinical models or a home based program that bears resemblance to current hospice models. Covenant Health has chosen a dedicated clinical space after visiting M.D. Anderson Cancer Center, but it national trends have yet to support the most effective model.

- **Related Category 3 Outcome Measure(s):**
  OD 13-Palliative Care
  IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure);
  IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure);
  IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) *(Non-standalone measure)*

  Evidence-based programs such as the one implemented at California Pacific Medical Center have proven successful and can be replicated. Other programs such as those cited in the November/December 2011 issue of Oncology Issues-Oncology Economics & Program Management: (Skudlarska, B.; Simo, S.; Keller, J.; Parniawski, P., [2011] "Geriatrics & Oncology-Partners in Palliative Care; Currin, J. [2011] "Partnering to Provide Inpatient & Outpatient Palliative Care"; Sargent, M.K.l [2011] " Palliative Care in the Hospital Setting". California Pacific Medical Center Data, 2011, showed a $2.2 million savings by decreasing LOS and improved in pain management scores by patients. In addition patient satisfaction improved with a strong correlation to improved communication.

The Center to Advance Palliative Care (CAPC.org) offers evidence of improved pain management, increased treatment preferences and documented valuation for spiritual care counseling for palliative programs such as the one proposed by the Covenant Outpatient Palliative Clinic. We believe that communication improves when patients are offered appropriate treatment options. Currently the palliative unit has 15-20% readmission rate and this signifies potential savings of $13,635 per patient who is at risk of readmitting.

Implementation of these evidence-based components validated by these practices will lead to achievement of improved pain management, improved documentation of treatment preferences and decrease in admission to ICU units in the last 30 days of life. An outpatient setting with a physician who has palliative care expertise for pain management and who can address treatment options as well as social workers to assist in transitional care will add to the success of the proposed program.

The low-income population of our community is more likely to fall between the cracks without appropriate programs due to their low health literacy and access to the appropriate providers. Establishing linkages to the community and collaboration with oncologist, pulmonologist and cardiologist will ensure that the low-income individuals in our community have access to this program.

- **Relationship to other Projects:** 127319504.2.1: Asthma Pediatric Navigation program (2.9), 139461107.2.2: Covenant Adult Patient Navigation Program (2.9) and 139461107.2.3: Covenant Transitional Outpatient Psychiatric Clinic (2.17) complements the Covenant Outpatient Palliative Clinic since together they all address both the pediatric and adult at-risk populations. Covenant Health System is committed to evolving and adapting to the new and changing healthcare environment and utilizing more cost effective and efficient, higher quality care options to achieve improvements in patient outcomes.

  The Covenant Outpatient Palliative Clinic complements the other programs by providing outreach through a clinic setting for patients who need medication management and appropriate treatment options for end-stage chronic conditions, decision making and spiritual care. The project has direct relation with Category 4 by impacting potentially preventable admission and readmission rates, ED utilization and Patient Satisfaction.

- **Plan for Learning Collaborative:** Our RHP will encourage participation by all partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the population in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:** RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines, the valuation considers that

the Covenant Outpatient Palliative Clinic aims to expand the care beyond the walls of the hospital will assure the patients continue to receive high-quality, patient-centered care post-inpatient admission. The Covenant Outpatient Palliative Clinic will meet the triple aim of assuring patients receive high-quality and patient-centered care, in the most cost-effective ways by implementation of creative transitional mechanisms that improve fragmented care. The current palliative care models provide invaluable emotional and spiritual support to patients and families faced with end-of-life issues, which aligns with high-quality and patient-centered care. Economically, trends have supported that palliative care reduces costs related to high acuity care for terminally ill patients, which speaks to the third aim of cost-effectiveness. Through our internal database (Amalga, for the period of 10/01/2011-10/01/2012), 438 patients were admitted to our intensive care units with CHF, COPD and Cancer with 64 of those admitted again within 30 days.

Covenant Palliative Outpatient Clinic will improve the health care infrastructure by expanding services that will improve the lives of Medicaid and uninsured residents of our counties by establishing an internal and external robust referral system into the program. Through the implementation of this program, patient care will be coordinated beyond the hospital admission and improve knowledge deficits for clients about appropriate treatment options. These treatment options could potentially also result in savings. With knowledge about their treatment options, patients, family and their caregivers can make educated decision about admissions into ICU units and other costly medical choices.

Modeling this program after a similar one, such as the California Pacific Medical Center, which showed a $2.2 million in savings by decreasing LOS and a decrease in pain scores, will benefit the community and save costs. Other like programs are those cited in the November/December 2011 issue of Oncology Issues-Oncology Economics & Program Management: (Skudlarska, B.; Simo, S.; Keller, J.; Parniawski, P., [2011] “Geriatrics & Oncology-Partners in Palliative Care; Currin, J. [2011] “Partnering to Provide Inpatient & Outpatient Palliative Care”; Sargent, M.K.l [2011] “ Palliative Care in the Hospital Setting”.

Currently the in-patient Palliative unit yearly census ranges from 500-600 encounters. 45-50% of patients in the unit are at their end of life stage so the remaining 50% (250-300) would qualify for the outpatient services. We expect to grow the program to serve 300 patients in the clinic by DY 5. More specifically, we expect to provide consults to 150 patients in DY 3, 225 patients in DY 4 and 300 in DY 5. These consults will include counseling to seriously ill patients with an interdisciplinary approach regarding life expectancy, sickness, pain, treatment, social and spiritual care, and patient and family preferences. We expect 175 patients in DY 3 and 220 patients in DY 4 to discharge to home care, hospice or a SNF. Additionally, we expect to increase the number of patients who die in our facility and receive palliative care consults.

Unique Identifier 139461107.2.4	Project Option 2.10.1	Project Components 2.10.1.a-d	Project Title Covenant Outpatient Palliative Clinic 2.10 Use of Palliative Care Programs
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.4 139461107.3.5 139461107.3.6	Reference Number IT-3.13.1 IT-3.13.2 IT-3.13.5	Outcome IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure); IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure); IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1 Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program <u>Metric 1</u> P-1.1 Metric: Business Case Baseline/Goal: With our current inpatient palliative care program in mind, we need to develop the business case for the outpatient palliative care program, which would include the goal to enroll 300 patients by DY5. Data Source: Business case write-up; documentation of planning activities Milestone 1 Estimated Incentive	**Milestone 2** P-5 Implement/expand a palliative care program <u>Metric 1</u> P-5.1 Metric: Implement comprehensive palliative care program: Charter for Palliative Care program; operational plan; palliative care team and hiring agreements Baseline/Goal: Based on the business case, staff will be hired to expand evidence based palliative care services in the outpatient setting. Data Source: Palliative Care Program Milestone 2 Estimated Incentive Payment: $1,349,870.50 **Milestone 3**	**Milestone 4** P-6 Increase the number of palliative care consults <u>Metric 1</u> P-6.1 Palliative care consults meet targets established by the program Numerator: Number of palliative care consults Denominator: Target number of palliative care consults Baseline/Goal: We will establish the baseline and expect to see an incremental increase in DY 4 and a total of 225 DY 5. Data Source: EHR, palliative care database Milestone 4 Estimated Incentive Payment: $1,353,794.50	**Milestone 6** P-6 Increase the number of palliative care consults <u>Metric 1</u> P-6.1 Palliative care consults meet targets established by the program Numerator: Number of palliative care consults Denominator: Target number of palliative care consults Baseline/Goal: 300 in DY 5 Data Source: EHR, palliative care database Milestone 6 Estimated Incentive Payment: $1,118,352.00 **Milestone 7** I-10 Among patients who died in the hospital increase the proportion of those who received a palliative care consult

Unique Identifier 139461107.2.4	Project Option 2.10.1	Project Components 2.10.1.a-d	Project Title Covenant Outpatient Palliative Clinic 2.10 Use of Palliative Care Programs
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.4 139461107.3.5 139461107.3.6	Reference Number IT-3.13.1 IT-3.13.2 IT-3.13.5	Outcome IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure); IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure); IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $2,474,678.00	I-9 Palliative care patients transitioned from acute hospital care into hospice, home care or a skilled nursing facility (SNF) with and without hospice services. <u>Metric 1</u> I-9.1 Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice or SNF Denominator: Total number of palliative care discharges Baseline/Goal: Through our inpatient palliative care program we provide support and education on the option to discharge to more comfortable settings when appropriate. With the Covenant Palliative Outpatient Clinic, we expect this number to increase as patients will be able to access ongoing care outside the hospital. 35% (175 patients)	**Milestone 5** I-9 Palliative care patients transitioned from acute hospital care into hospice, home care or a skilled nursing facility (SNF) with and without hospice services. <u>Metric 1</u> I-9.1 Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice or SNF Denominator: Total number of palliative care discharges Baseline/Goal: Through our inpatient palliative care program we provide support and education on the option to discharge to more comfortable settings when appropriate. With the Covenant Palliative Outpatient Clinic, we expect this number to increase as patients will be able to access	<u>Metric</u> 1-10.1 Percent of total in-hospital deaths who had a palliative care consult Numerator: Number of patients who died in the hospital and received at least one palliative care consult Denominator: Number of patients who died in the hospital. Baseline/Goal: We expect this percentage to increase with the expansion of palliative care services. In DY 1, we estimate 72% (697/942) of patients who die at CH receive a palliative medicine consult. By DY 5 our goal is 80% of patients.) Data Source: EHR, data warehouse palliative care database Milestone 7 Estimated Incentive Payment: $1,118,352.00

Unique Identifier 139461107.2.4	Project Option 2.10.1	Project Components 2.10.1.a-d	Project Title Covenant Outpatient Palliative Clinic 2.10 Use of Palliative Care Programs
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.4 139461107.3.5 139461107.3.6	Reference Number IT-3.13.1 IT-3.13.2 IT-3.13.5	Outcome IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure); IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure); IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Data Source: EHR, data warehouse, palliative care database Milestone 3 Estimated Incentive Payment: $1,349,870.50	ongoing care outside the hospital. 40% (220 patients) Data Source: EHR, data warehouse, palliative care database Milestone 5 Estimated Incentive Payment: $1,353,794.50	**Milestone 8** I-9 Palliative care patients transitioned from acute hospital care into hospice, home care or a skilled nursing facility (SNF) with and without hospice services. <u>Metric 1</u> I-9.1 Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice or SNF Denominator: Total number of palliative care discharges Baseline/Goal: Through our inpatient palliative care program we provide support and education on the option to discharge to more comfortable settings when appropriate. With the Covenant Palliative Outpatient Clinic, we expect this number to increase as patients will be able to access ongoing care outside the hospital. 40% (650 patients) Data Source: EHR, data warehouse,

Unique Identifier 139461107.2.4	Project Option 2.10.1	Project Components 2.10.1.a-d	Project Title Covenant Outpatient Palliative Clinic 2.10 Use of Palliative Care Programs
Covenant Medical Center			139461107
Related Category 3 Outcome Measure(s):	Unique Identifier 139461107.3.4 139461107.3.5 139461107.3.6	Reference Number IT-3.13.1 IT-3.13.2 IT-3.13.5	Outcome IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure); IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure); IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			palliative care database
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $2,474,678.00	Year 3 Estimated Milestone Bundle Amount: $2,699,741.00	Year 4 Estimated Milestone Bundle Amount: $2,707,589.00	Year 5 Estimated Milestone Bundle Amount: $2,236,704.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $10,118,712.00			

Project Option: 2.8.6 Improve Efficiencies: Reduce Inappropriate Emergency Department Use
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.2.1

- **Provider:** GPCH is a 25-bed hospital in Borger, Texas serving an 895 square mile area and a population of approximately 21,000 (primary) and an additional 30,000 (tertiary).
- **Intervention(s):** GPCH will create an alternative service area on the hospital grounds to provide non-emergent care outside of the emergency department to patients who come to the ED with non-emergent conditions, thereby reducing emergency treatment time for emergent patients, reducing the cost of services for patients that do not present with emergent conditions and maintaining availability of emergency treatment capacity. This will require investment in infrastructure, staff training, and patient education at the ED triage site.
- **Need for the project:** Presently, 44% of residents within GPCH's catchment area are either uninsured or Medicaid-eligible. These patients often seek primary and non-urgent care services in the emergency department because they do not have affordable access to primary care providers in the community. The average cost of uncompensated care for an ED visit is $1,200. GPCH believes that reduced use of the ED by patients without emergent conditions will benefit the patients' health outcomes, will improve the ED experience for truly emergent patients, and will leave available funds that GPCH may redirect toward improving its provision of primary and preventative care in the community.
- **Target population:** The target population of this project is uninsured and Medicaid-eligible patients who present to the ED with non-emergent/urgent conditions. GPCH's Medicaid-eligible and uninsured patients comprise 44% of the patienco presenting at the ED. In 2012, GPCH provided 9,971 ED visits , of which 46% were Medicaid-eligible or uninsured (4,551 visits). An average of 8% of those visits are Level 1 or Level 2 (i.e. non-emergent), meaning that approximately 800 patients could be treated in an urgent care setting. GPCH ED staff will screen each of the approximately 10,000 patients presenting in the ED for potential triage to the urgent care area.
- **Category 1 or 2 expected patient benefits:** This project seeks to increase the number of ED visits that are triaged from the GPCH ED to this new service area by 100% over the baseline year of operation in DY3 (which GPCH expects to represent 300 visits) by DY5, which will improve patient access to the appropriate level of care in the right setting and provide affordable care.
- **Category 3 outcomes:** IT 9.2 – By DY5, GPCH expects this project to reduce all ED visits from residents of Hutchinson County by 7% from the baseline.

Project Option: 2.8.6 Improve Efficiencies: Reduce Inappropriate Emergency Department Use
Performing Provider: Golden Plains Community Hospital (GPHC LLC)/197063401
Unique Project ID: 197063401.2.1

Project Components: Must tie to Category 3 Outcome Domain 9

Project Description:
GPCH will create an alternative service area on the hospital grounds to provide non-emergent care outside the emergency department to Hutchinson County patients who come to the ED with non-emergent conditions, thereby reducing emergency treatment time for emergent patients and maintaining availability of emergency treatment capacity. A reduction in the misuse of the ED will reduce the cost of providing health care to the indigent community, thereby allowing GPCH to invest those savings into better primary and preventative care, which in turn leads to improved health outcomes for the indigent community.

In order to be successful, the project must include the following: identifying available space, equipping of the space, identifying staff to treat the non-emergent patients, provider training on triaging to the new space, and increasing provider adherence to the triage policy.

Project goals: The goal of this project is to increase the triage of Hutchinson County patients presenting to the ED with non-emergent conditions into this new space for treatment and/or medical advice. The purpose behind doing this is to keep the ED capacity available for actual emergencies, to reduce costs (visits to the ER are more expensive than other types of visits), and to improve patient outcomes.
o This project seeks to increase the number of Hutchinson County patients triaged from the ED to this new service area by 10% over the baseline year of operation.

Project challenges: Expected challenges include identifying appropriate floor space within the existing facility offering suitable provisions for patient care and workflow, and identifying adequate nurse staffing. GPCH will use DY 2 to plan for these challenges so that the transition to a new service delivery apparatus will not be problematic.

Five Year Expected Outcome: As discussed above, the expected outcome of this project is the implementation of a new service area at GPCH that will provide an alternative to misuse of the ED, and a 10% increase in the use of this alternative delivery space in DY5 over the year of implementation.

Relationship to Regional Goals: This project is related to the regional goal of transforming the health care delivery system to provide coordinated care that benefits patient satisfaction, patient outcomes, and the cost of providing care.

Starting Point/Baseline:
During DY2, GPCH will seek to determine the following: the number of Hutchinson County patients seen annually in the ED who are determined to be non-emergent; the number of Hutchinson County patients who cannot or do not access primary care before visiting the ED, the number of Hutchinson County patients presenting with no primary care provider and the number of Level 1 Hutchinson County patients who are treated in the ED

Rationale:
GPCH chose this project because in Rural Region 12, 5.2% of children under 19 years of age are uninsured, and 23% of residents went without health insurance for the last 12 months, as measured in 2010. These residents are much more likely to misuse the ED, as they have limited access to primary care in their communities (which is endemic statewide). In telephone surveys of residents in Rural Region 12, 4% admitted to using the ED when they are sick or need healthcare advice. The use of the ED is much more expensive than urgent, primary, or preventative care; thus, treating patients who have come to the hospital ED elsewhere within the hospital and by nurses instead of ED physicians will reduce the cost of providing health care in the community.

Milestones and metrics: GPCH chose the milestones and metrics it did to allow for development, implementation and the placement of infrastructure for the triage system (which will require staff training, dedication of space, and development of policies) during DYs 2 and 3, while seeking to improve the use of the new system in DYs 4-5 (which will be evidenced by increased compliance with the triage policies by the ED admitting staff). These milestones and metrics will help GPCH reduce misuse of the ED, which is prevalent in Region 12.
Community Needs Assessment ID Numbers: CN.1, CN.2, and CN.3
New Initiative: This is a brand new initiative for GPCH**.**

Related Category 3 Outcome Measures:
OD – 9 Right Care, Right Setting
Process measure: P2 (establish a baseline)
IT-9.2 ED Appropriate Utilization

OD 9, IT 9.2 is the required outcome for this project in the Planning Protocol. Reducing inappropriate use of the ED is the stated goal of this project, which is necessary in order to reduce health care costs and to improve patient outcomes and access to the right level of care in a more appropriate setting.

Relationship to Other Projects:
This project ties to Category 4, RD:5 in that it is aimed at improving timely access to emergency care for those who are truly emergent. Additionally, this project is related to GPCH's two Category 1 projects (Expanding Primary Care through an Internist and OB/Gyn) in that each of these projects aims to reduce misuse of the ED.

Relationship to Other Performing Providers Projects in the RHP and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Using a scoring system of 1-5, GPCH valued this project as follows: This project enables patients to receive the treatment they were seeking when they presented to the ED, but without the high cost. The patients will be treated at the hospital by skilled nurses, who can refer the patients elsewhere if it becomes clear that the patient needs a higher level of care. This project is aimed at delivering services to Hutchinson County residents outside of the emergency room when their conditions are non-emergent, which will improve the ED's capacity to treat Hutchinson County residents presenting with emergent conditions. The act of triaging patients out of the ED will require coordination between the new service delivery area and hospital staff (to be sure that the patient receives the right care in the right setting). Finally, the patients treated in this new service area will receive medical attention and advice on the hospital grounds without having to be admitted to the ED, which will improve costs and prevent complications that can arise from being admitted to the hospital.	**4**
Addresses Community Need(s)	As noted above, this project addresses the three most acute community needs in Region 12 - CN.1 (Severe primary care provider shortage, wait time, expense, lack of insurance and access to care); CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact); and CN.3 (Poor insurance support or uninsured and surveys). Additionally, approximately 1/3 visitors to GPCH's emergency department are non-emergent, so there is a clear need to defer these patients to a safe, affordable, an easily accessible area for treatment.	**3**
Project Scope/Size	• Outreach to the targeted population via posters, internet, social media, and word of mouth. • This project will require GPCH to hire and/or train additional RNs to operate the alternative service area. • This project will result in savings for patients and providers. An outpatient visit to a doctor's office can range from $40-75 dollars, as compared to the ED professional and technical fees as a minimum being more than $350. Decreasing unnecessary ED use can result in a saving of up to $300 a patient per visit.	**3**
Project Investment	• Human resources (recruiting and training RNs; educating ED providers; identifying space) • Equipment purchase and maintenance (segregating and equipping the new space to essentially function as a mini-clinic) • Time to implement – (2 years to develop, implement, and create the system; 2 years to improve the use of the system) Total value of this project/total value of all GPCH Category 1&2 projects: 15/61	**5**

197063401.2.1	***2.8.6***	***2.8.6.MUST TIE TO CAT 3 OUTCOME DOMAIN 9***	***IMPROVE EFFICIENCIES: REDUCE INAPPROPRIATE EMERGENCY DEPARTMENT USE***
GPCH LLC Golden Plains Community Hospital			*197063401*
Related Category 3 Outcome Measure(s):	*197063401.3.4*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Draft and implement a plan to establish a distinct space within the hospital for treating patients that have been triaged out of the ED as non-emergent. **<u>Metric 1</u> [P-X.1]:** Identify space, equip space, staff space with RNs to treat non-emergent patients **Baseline/Goal:** Set up the physical space and create the infrastructure for operating the triaging program. **Data Source:** The plan, hospital records of steps taken **Milestone 1 Estimated Incentive Payment: $ 587,200**	**Milestone 2 [P-Y]:** Implement the policy of triaging patients who are non-emergent from the ED into the new space within the hospital **<u>Metric 1</u> [P-Y.1]:** Adoption and use of the policy **Baseline/Goal:** Set a baseline for the number of patients triaged out of the ED into the new service area; goal of triaging 300 visits during DY3. **Data Source:** documentation of the policy and EHR records showing the number of triaged patients versus the number of patients ultimately determined non-emergent **Milestone 2 Estimated Incentive Payment:** $ 774,716	**Milestone 3 [I-Y]:** Increase adherence to the triage policy by staff working in the ED **<u>Metric 1</u> [I-Y.1]:** Increased percentage of patients deemed non-emergent triaged to the new space, as compared to DY3 **Baseline/Goal:** 50% increase in the number of ED visits deemed non-emergent by GPCH staff and then triaged to the new service area, compared to DY3 baseline (estimated 450 visits triaged to appropriate care setting) **Data Source:** Electronic health records of the patients who present to the ED **Milestone 3 Estimated Incentive Payment:** $922,793	**Milestone 4 [I-Y]:** Increase adherence to the triage policy by staff working in the ED **<u>Metric 1</u> [I-Y.1]:** Increased percentage of patients deemed non-emergent triaged to the new space, as compared to DY4 **Goal:** 100% increase in the number of ED visits deemed non-emergent and then triaged to the new service area, compared to DY3 baseline (estimated 600 visits triaged to appropriate care setting) **Data Source:** Electronic health records of the patients who present to the ED **Milestone 4 Estimated Incentive Payment:** $853,719
Year 2 Estimated Milestone Bundle Amount: $ 587,200	Year 3 Estimated Milestone Bundle Amount: $ 774,716	Year 4 Estimated Milestone Bundle Amount: $ 922,793	Year 5 Estimated Milestone Bundle Amount: $ 853,719
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 3,138,428			

Project 2.1.3 Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative.
Performing Provider: Golden Plains Community Hospital/197063401
Unique Project ID: 197063401.2.2 – **"PASS 2"**
Project Components: 2.1.3.a-f

Provider: GPCH is a 25-bed hospital in Borger, Texas serving a 895 square mile area and a population of approximately 21,000 (primary) and an additional 30,000 (tertiary).

Intervention(s): This project will implement the medical home model in GPCH's Borger clinic (which is being moved into a much larger space, offering expanded clinic hours, and adding additional medical and clinical staff), and will seek to recruit community physicians in private practice to participate in providing medical homes for indigent and uninsured patients seen at the clinic.

Need for the project: GPCH currently has only one internist on staff at the Borger clinic, which does not allow for easy access to physician services at the clinic. The medical home model will provide patients with access to ancillary services, such as case management and care coordination, which will enable patients to better manage their conditions and prevent onset/deterioration of chronic diseases. Presently, the wait for third next available appointment is 14 days.

Target population: The target population of this project is Medicaid and uninsured residents in the Borger catchment area, who are unlikely to have a medical home through which to receive primary care. GPCH's community clinics provided approximately 7,000 encounters in 2012 to approximately 3,000 unique patients, 46% of which were Medicaid/self-pay. The Borger clinic is being expanded in DY2 and will likely absorb many of these patients.

Category 1 or 2 expected patient benefits: Through implementing the medical home model at the Borger clinic, GPCH will improve the availability of third next available appointments at patients' medical homes by 3 days by the end of DY5, and GPCH will increase the number of Medicaid/self-pay clinic patients enrolled in the Borger clinic medical home by to50% of the Medicaid/uninsured clinic population by the end of DY4 (which GPCH anticipates to include approximately 700 unique patients).

Category 3 outcomes: IT-9.2 - Our goal is to reduce all visits to GPCH's ED by 10% under the baseline established in DY3 by DY5.

Project Option Title: 2.1.3 Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative
Performing Provider: Golden Plains Community Hospital/ 197063401
Unique RHP Project ID: 197063401.2.2 – **"PASS 2"**

- **Project Description:**

  This project will work to build a cohesive care team and to establish a home base for GPCH and Hutchinson County patients at the Borger Clinic, where patients will have a health care team tailored to their health care needs. The Borger clinic medical home will allow GPCH's clinic to provide preventive, primary, routine and chronic care proactively, so that the patients may see their health improve, rely less on costly emergency department visits, incur fewer avoidable hospital stays, and report a greater patient experience of care. Specifically, GPCH intends to recruit physicians in the community to participate in providing the medical home to indigent patients in the community at the Borger clinic. GPCH patients will be assigned to a physician from within the pool of participating physicians, and will have access to additional providers within the Borger clinic for services such as case management and care coordination.

  Project Goals: The ultimate goal of this project is to increase the number of clinics using the medical home model.

  - The Borger Clinic will improve the availability of third next available appointments for patients' medical homes by 2 days.
  - The Borger Clinic will increase the number of Medicaid/self-pay clinic patients enrolled in the Borger clinic medical home by 50% by the end of DY4.

  Project challenges: Expected challenges include that Texas physicians usually move into our rural environment to gain professional independence. This tendency will make changing the mindset of the treating physicians the biggest challenge. Golden Plains will need to identify and recruit physicians to participate in creating these medical homes, train GPCH staff in the evidence-based methods for creating and maintaining a medical home for these patients, and educate patients about the benefits of consistent primary and preventative care.

  5 year expected outcome: The expected outcome of this project is earlier intervention in disease process and reduced cost to the health care system, allowing the patients a better quality of life.

Relationship to Regional Goals: This project addresses Region 8's goal to transform health care delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

- **Starting Point/Baseline:**

No medical home model currently exists in GPCH's community or Hutchinson County. GPCH has one internist on staff at the Borger clinic, but the rest of the primary care physicians in the community operate in private practice. Most commercial patients (i.e. commercially insured) already have a medical home, so this project aims to assign indigent and Medicaid patients into the medical home program. GPCH currently provides 7000 clinic encounters to approximately 3000 patients annually, 46% of whom are Medicaid/self-pay.

- **Rationale:**

GPCH chose this project because the entirety of Hutchinson County is a Federally Designated Health Professional Shortage Area, which takes into account patient to provider ratios as well as distance to care factors. Additionally, the Community Needs Assessment within the RHP Plan identifies the shortage of primary care professionals as a "Tier 1" critical issue for Region 12. The Borger medical community currently provides a fair level of primary care to the people of Hutchinson County, but it does not currently offer a primary care clinic that has embraced the medical home model. The new clinic(s) will embrace this model, and create coordinated care for Hutchinson County residents, leading to better patient health outcomes and reduced costs in providing care.

This project will incorporate the required core components, which include:

i. Empanelment: GPCH will assign all patients in the clinic adopting the Medical Home Model to a primary care provider within the medical home.

ii. GPCH will restructure clinical staff into multidisciplinary care teams that manage a panel of clinic patients..

iii. GPCH will link patients to a provider and care team through the clinic so both patients and provider/care team recognize each other as partners in care.
iv. GPCH will assure that patients are able to see their provider or care team whenever possible.
v. GPCH will promote and expand access to the medical home by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits.
vi. GPCH will conduct quality improvement for project by identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Milestones and metrics: GPCH chose its DY 2-3 milestones in order to establish the medical home model in its Borger Clinic and to then put in place policies to enable patients to enjoy greater access to the medical home model upon becoming patients at the clinic. GPCH chose its DY4 milestone because one goal of the project is to integrate new patients of the clinic into the medical home model and to improve the timely provision of care. GPCH chose its DY5 milestone because the other goal of this project is for patients to actually use and benefit from the use of the medical home model; thus, it is important to measure and increase the number of visits for patients in a medical home at their medical home.

Community Needs ID Numbers: This project addresses the following Region 8 Community Needs: CN.1, CN.2, CN.3, CN.4, CN.5, CN.6, and CN.11

New initiative: this is an entirely new model for the Hutchinson County medical community, which is expected to improve patient outcomes and reduce the cost of providing healthcare to indigent residents of the County.

- **Related Category 3 Outcome Measure(s):**

OD – 9: Right Care, Right Setting

Process measures: P2 (establish a baseline) and P1 (project planning)

IT: 9.2 – ED appropriate utilization (reduce non-emergent visits to GPCH's ED by 10% by DY5)

GPCH chose this outcome because the goal behind implementing the medical home model is to decrease the need/inclination for indigent or uninsured patients to seek episodic care at the local emergency room (which is costly and does not improve patient outcomes).

- **Relationship to other Projects:**

  This project is tied to GPCH's recruitment of an Internal Medical Physician and an OB/GYN, who can form part of patients' primary care teams (Unique Project IDs: 197063401.1.2 and 197063401.1.3). Additionally, this project is related to the Category 4 reporting domain titled "Potentially Preventable Readmissions," as GPCH expects the use of the medical home model to provide improved support to recently discharged patients, better enabling those patients to avoid PPRs (Unique Project ID: 197063401.4.3).

- **Relationship to Other Performing Providers' Projects in the RHP:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

  The valuation of each GPCH project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project is considered high in value because it meets the triple aims of the waiver, will serve a wide population base, and will take a substantial investment to establish.

  Valuation scores (1-5 scale)

  Addresses Triple Aims of the Waiver: 4 (reduces the cost of providing care by providing earlier and more frequent prevention and intervention into patient conditions, and centers the provision of care around the needs of the patient)
  Addresses Community Needs: 4 (Borger Clinic patients and others in Hutchinson County who become new patients will benefit from this program; the population suffers from a lack of coordinated primary care and a high rate of chronic disease)
  Project Size/Scope: 3 (this project will start in the Borger Clinic, but GPCH hopes to extend the medical home model to other clinics/providers in the area, in order to establish a patient-friendly network of providers)
  Project Investment: 3 (developing and implementing a plan will take time and resources; staff will require training, and additional technological tools may be necessary for coordination.

197063401.2.2 – "PASS 2"	2.1.3	2.1.3.A-F	Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative.	
Golden Plains Community Hospital				197063401
Related Category 3 Outcome Measure(s):	197063401.3.5	IT-9.2	ED appropriate utilization	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Implement the medical home model in primary care clinics. Metric P-1.1: Increase number of primary care clinics using medical home model Baseline/goal: implement the medical home model into the Borger clinic, and reach out to other Hutchinson County area providers to seek their involvement. Implementation will include patient empanelment, multidisciplinary provider teams, and determining methods for increasing patient access to their medical home providers. GPCH currently treats 3000 patients in its clinics, and will seek to empanel members of the Medicaid/uninsured clinic population first over DYs 2-3, which is comprised of 1380 patients. As a starting point, GPCH will	Milestone 2 P-2: Put in place policies and systems to enhance patient access to the medical home. Metric P-2.1: Performing Provider policies on medical home Baseline/goal: establish a system for increasing utilization of the medical home by patients seen in the Borger Clinic Data Source P-2.1a: Performing Provider's "Policies and Procedures" documents		**Milestone 3** I-12: Based on criteria, improve the number of eligible patients that are assigned to the medical home. Metric I-12.1: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by Performing Provider. **Baseline/goal**: GPCH seeks to empanel its Medicaid/self-pay clinic patients into the Borger medical home ("eligible patients"). GPCH estimates that it currently treats 1380 Medicaid/self-pay clinic patients annually, and seeks to have 50% of eligible patients enrolled by the end of DY4 (an estimated 700 patients). Data source I-12.1c: Practice management system, EHR ***Milestone 3 Estimated Incentive Payment:***	**Milestone 5** I-14: Patient access to medical home **Metric** I-14.1: Third next available appointment **Baseline/goal:** The third next available appointment time is currently 14 days at GPCH's clinics. GPCH expects a decrease the number of days until third next appointment for medical home enrollees by at least 3 days from DY2 baseline numbers. **Data Source** I-16.1c: Practice management system and/or scheduling system. *Milestone 5 Estimated Incentive Payment:* $386,939

197063401.2.2 – "PASS 2"	2.1.3	2.1.3.A-F	Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative.	
Golden Plains Community Hospital			197063401	
Related Category 3 Outcome Measure(s):	197063401.3.5	IT-9.2	ED appropriate utilization	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
empanel 50 patients into the Borger clinic medical home during DY2. Numerator: Number of primary care clinics using medical home model Denominator: Total number of primary care clinics Data Source Documentation of implementation *Milestone 1 Estimated Incentive Payment:* $488,792	*Milestone 2 Estimated Incentive Payment:* $510,471		$243,596 **Milestone 4** P14: Participate in face-to-face learning at least twice per year with providers and the RHP to promote collaborative learning. **Metric:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data source:** Documentation of meetings, including agendas, slides, or notes ***Milestone 4 Estimated Incentive Payment:*** $243,596	
Year 2 Estimated Milestone Bundle Amount: $488,792	Year 3 Estimated Milestone Bundle Amount: $510,471		Year 4 Estimated Milestone Bundle Amount: $487,193	Year 5 Estimated Milestone Bundle Amount: $386,938
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,873,394				

Project Option: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Performing Provider: Hemphill County Hospital / 109588703
RHP Unique Identification Number: 109588703.2.1
Project Components: 2.9.1.a-e

Provider: Hemphill County Hospital is a 26 bed facility located in Canadian, Texas. This county has a total area of 906 square miles and is the only town in the county as well as the only hospital. Two of the three counties surrounding Canadian, Roberts and Lipscomb, have a total square mileage of 924 and 932 respectively. Neither of these counties have a hospital. The nearest tertiary care hospital is 110 miles from Canadian. The population we serve in Hemphill County is 3,970 according to the 2011 estimate of the United States Census Bureau Quick Facts.

Intervention: This project will implement a navigation service to provide assistance to ER patients that do not have primary care providers and are at risk of disconnect from institutionalized health care. This will allow the community health worker to connect with patients of high past utilization of inpatient and emergency services.

Need for the project: We currently do not have a navigation program and have noticed an increase in non-emergent ER visits, many of which are related to avoidable causes. (ie; chronic care, no PCP)

Target population: The target population is our patients that do not have a PCP but have moved to the area and may have chronic conditions or just lack of knowledge of what is available. Our project will target approximately 250 patients through our ED department that are at risk for fragmented care of have no PCP. Approximately 25% or 63 of these 250 patients are Medicaid or Uninsured.
Category 1 or 2 expected patient benefits: By providing navigation services to targeted patients, this project expects to see improvements in coordination of care for patients enrolled in the program as well as increase the number of patients who have a PCP that did not before the program. An increase in patient engagement activities, such as patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources our expectation/goal is to increase the number of target patients enrolled in the program so as to see an expected patient benefit by DY4 will be to serve 40% or 25 patients and 60% or 38 patients by DY5.

Category 3 outcomes: IT-6.1 Our goal is to have a percent improvement over baseline of patient satisfaction scores. This outcome was chosen in order to provide a standardized survey tool and data collection methodology for measuring patients' perspectives on hospital care. Our target is for an increase of 2 basis points in the overall rating on the ED post-discharge NRC Picker patients satisfaction survey in DY4 and 2 basis points again in DY5.

Project Option: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Performing Provider: Hemphill County Hospital / 109588703

RHP Unique Identification Number: 109588703.2.1

Project Components: 2.9.1.a-e

- **Project Description: Hemphill County Hospital proposes to provide navigation services to targeted ER patients who are at high risk of disconnect from institutionalized health care.**

  Although access to primary care is important in improving quality of care and reducing avoidable hospitalizations, often patients, especially safety net patients, face an additional burden in navigating the health care system due to fragmentation of care and little communication among providers. For this reason, we propose implementing a navigation program for populations most at risk of receiving disconnected care.

  This project would help and support patients especially in need of coordinated care navigate through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. This will also result in a greater patient experience of care. The ER Navigation Program will provide a Community Health Worker (CHW) who will collaborative with appropriate resources and will be responsible for navigating high-risk patients through the health care system. This CHW would contact the patient and would educate them of the importance of primary care. The CHW would also coordinate with local clinics to provide appointment slots that can be given to the patient within 3 days of discharge. Assigning patients to a medical home from the ED has been shown to reduce avoidable ED visits.

  Criteria for the program would be patients with high past utilization of inpatient and emergency services. This core component (a) will identify frequent ED users and use a navigator as part of a preventable ED reduction program. Research has shown that among the safety net population, nearly 4% of the patient population account for nearly half of all costs, indicating a need for intervention within the population. Patients are often most at risk of facing difficulty navigating the health care system once they leave the emergency department. Patients often present to the ED for non-urgent conditions that could have been treated in a primary care setting. Although estimates vary, up to 49% of emergency department visits are for avoidable causes. With core component (b), our CHW will engage residents in the community at external venues, such as local businesses, churches, apartment complexes, and service organizations. With core components (c) and (d), the

CHW will ensure proper access to care, appointment scheduling, work with proper resources for Medicaid/CHIP enrollment, and will use targeted outreach strategies and health education reach patients. Once identified, patients will receive follow-up phone calls, communication, education and support from the CHW to ensure that patients keep appointments and have the resources they need. This will also include working with local physician clinics to increase access to care as well as providing educational classes for disease management. In order to minimize the risks of potential failure and of potential adverse or unanticipated side effects, Core component (e) will be used to conduct quality improvement for our project which will consist of identifying project impacts, lessons learned, and any opportunities to scale all or part of the project to a broader patient population. This will allow us to formulate change concepts that may improve the process outcomes.

- **Goals and Relationship to Regional Goals:**

  The goal of this project is to use a navigation program/community health worker to provide enhanced care coordination, community outreach, social support to vulnerable and/or high-risk ER patients. The program will help and support these patients to navigate through the continuum of health care services throughout their illness. They will ensure that patients receive coordinated, timely, and site-appropriate health care services. Assistance to connecting patients to family care providers in the area, as well as diverting non-urgent care from the ED to site-appropriate locations will be part of the program goals.

- **Project Goals:**

  - Reduce ED visits and avoidable admissions among patients receiving navigation services.
  - Increase the number of patients who are discharged from the ED with a primary care appointment within 3 days.
  - Provide at least 25% of patients in ED who need a medical home with a medical home assignment.

- **This project meets the following regional goals:**

  - Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system;

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the region, and improves health care outcomes and patient satisfaction.

The ER Navigation Program uses a patient-centered, coordinated care navigation model that aims to improve outcomes and improve satisfaction through timely access to appropriate care.

- **Provider Challenges:**

The primary challenge for this project will be to engage and build trust with patients. Also, HCH lacks a coordinated or systematic approach to identifying patients who need a medical home or who have difficulty navigating the health care system, and ensuring that they are both assigned a medical home and have a first appointment into that home. Establishing a navigation system for populations at risk receiving disconnected and fragmented care is a lacking regional resource.

- **5-Year Expected Outcome for Provider and Patients:**

Hemphill County Hospital expects to see improvements in coordination of care for patients enrolled in the program as well as increase the number of patients who have a PCP that did not before the program.

- **Starting Point/Baseline:**

Currently, a navigation program does not exist for ER patients at Hemphill County Hospital. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2.

- **Rationale:**

Hemphill County Hospital has chosen this project due to the vast population of migrant workers, uninsured and under insured patients in our region. Many use the ER for treatment due to lack of knowledge of the health care community and how to enter it. Being in a rural environment and the sole community hospital in the area, we are looked to as an authority in healthcare not only providing direct treatment but in educating the population in the ever changing healthcare climate. This program will help ease the fears of those who are disenchanted by the system. A patient navigator program will help

patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations, and other components of the health care system. Services provided by the ER patient navigator will include:

- Locating a family practice physician
- Making initial appointment with new PCP
- Increase the number of PCP referrals
- Facilitating follow-up of these appointments as well as others
- Increase patient education
- Self-management support
- Arranging financial support and assisting with paperwork

The community health worker will have close ties to the community and serve as an important link between the underserved and Hemphill County Hospital. CHW will be:

- Compassionate, sensitive, and culturally attuned to the people and community
- Knowledgeable about the environment and hospital
- Connected with critical decision makers inside the system

There is a need in the region for community education regarding preventive care. There is a vast population in this area. The migrant worker, uninsured, under insured, Medicaid and elderly compose a large percent of this region's population. Due to various reasons such as job layoffs, seasonal workers, poor education, communication barriers, transient workers, this population tends to use the emergency department for clinical care. The hospital serves a five county region. There are EMS services in some of the surrounding counties but no clinics or hospitals, thus the 2 physicians offices in Canadian have trouble seeing patients in the five counties. A community health worker would assist this population with education, parenting classes, wellness classes, healthy life styles as well as other educational opportunities. The CHW would help the underserved walk through the health network and thus use health services appropriately. Some of the people in these counties have no families and neighbors are few and far between. On more than one occasion, by the time this population gets into the health system, their health issues have compounded to the point that the expense to treat them is greater for one ER visit or hospital admission than the yearly salary of a CHW. After these cases are treated and sent home they often return in less than thirty days

because there is no one to help them maneuver through the health system. This then has become a learned behavior and we now have generations using the ED for clinic care, mostly due to lack of access or understanding of the programs available to them in the area.

- **Unique community Need identification numbers the project addresses:**

  - CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
  - CN.2- Lack of mental health services, inability to gen an appointment, lack of insurance, need to use ERs for initial contact
  - CN.3- Poor insurance support or uninsured
  - CN.4- High incidence of obesity, diabetes mellitus and heart disease
  - CN.10- High prevalence of asthma and care issues

How the project represents a new initiative or significantly enhances and existing delivery system reform initiative:

Currently, a patient navigation program does not exist for ER patients at Hemphill County Hospital. This initiative will improve access for targeted patients.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction:

IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Are getting timely care, appointments, and information
- Improve patient satisfaction over baseline – exact % TBD after establishing baseline
- Entrance into the navigation program can have a positive effect on outcomes
- Navigators will assist patients through the maze of the healthcare system resulting in higher patient satisfaction

Relationship to other Projects: Our 1 project focuses on medically disenfranchised patient's and ties to our RHP goals by assisting in transforming health care delivery from an episodic disease focused model of care to a patient-centered, coordinated care management delivery system that improves patient outcomes and satisfaction, reduces unnecessary or

duplicative services, and builds on accomplishments of our existing health care system. This will help us reach our Category 3 outcome.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project achieves waiver goals by utilizing a community health worker as a patient navigator to provide enhanced support to vulnerable and/or high-risk patients. It will also improve the knowledge base of providers as well as of patients, improve coordination among providers and patients, and will initiate active follow-up to ensure positive outcomes. Enhancing the patients' abilities to manage their own illnesses by gaining trust in the CHW. The Patient Care Navigation Program addresses the health care needs of those who are most vulnerable and/or high risk and should allow us to be able to prevent unnecessary ED visits, connect patients to primary care, and promote a healthier population.	**5**
Addresses Community Need(s)	The Patient Care Navigation Program will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. This project will meet the Community Needs (CN) by targeting the following: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN3- Poor insurance support or uninsured. CN4- High incidence of obesity, diabetes mellitus and heart disease CN10- High prevalence of asthma and care issues RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.3 and CN.4 have been defined as *Urgent Needs*, and CN.10 falls in the category of *Important Need But Less Urgent.*	**5**
Project Scope/Size	Hemphill County has a lot of transient workers who have no PCP in this area. There are also area residents who are not established with a PCP. By implementing a community health worker to assist and support the patients with navigation services, support for disease management and education will be imperative. Implementation will include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Social Worker, as well as guest speakers to support these patients navigating through the project.	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Navigation Program so our investment for this project will involve a large amount of time spent in development, education and training. Currently, we do not employ a community health worker and would incur costs of filling this position and possibly others. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**4**

109588703.2.1	**2.9.1**	**2.9.1.A-E**	**Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care**	
Hemphill County Hospital				**109588703**
Related Category 3 Outcome Measure(s):	109588703.3.1	**IT-6.1**	Percent Improvement over baseline Patient Satisfaction Score	

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: {P-3} Provide care management/navigation services to targeted patients. *Metric 1 {P-3.1}* Increase in the number or percent of targeted patients enrolled in the program. *Baseline/Goal:* Number of targeted patients enrolled in the program versus total number of targeted patients identified. *Data Source:* Enrollment Reports *Estimated Milestone 1 Incentive Payment:*$18,619	*Milestone 2: {P-4}* Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources *Metric 1: {P-4.1}* Number of classes and/or initiations offered, or number or percent of patients enrolled in the program *Baseline/Goal:* Number of patients enrolled in patient program versus number of patients eligible to participate in program as determined by provider. *Data Source:* Communication log and/or class participant lists *Estimated Milestone 2 Incentive Payment:* $21,582	*Milestone 3: [I-6}* Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. *Metric 1 [I-6.2]:* Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED. *Baseline/Goal:* Increase number of referrals – exact % TBD after establishing baseline *Data Source:* ER records *Estimated Milestone 3 Incentive Payment:*$21,805	*Milestone 4: [I-6}* Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. *Metric 1 [I-6.2]* Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED. *Goal:* Increase number of referrals – exact % TBD after establishing baseline *Data Source:* ER records *Estimated Milestone 4 Incentive Payment:* $18,682
DY 2 Estimated Milestone Bundle Amount: $18,619	DY 3 Estimated Milestone Bundle Amount: $21,582	DY4 Estimated Milestone Bundle Amount: $21,805	DY5 Estimated Milestone Bundle Amount: $18,682
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $80,688			

Project Title: 2.4.1 Implement processes to measure and improve patient experience
Performing Provider: Hereford Regional Medical Center/133544006
RHP Unique Identification Number: 133544006.2.2 – "PASS 3b"
Project Components: 2.4.1.a-d

- **Provider:** Hereford Regional Medical Center is a 42 bed hospital located in Hereford, TX serving a 1,498 square miles and a population of approximately 19,500.

- **Intervention:** Deaf Smith County is nationally recognized as a Health Provider Shortage Area (HPSA) so the recruitment and retention of new and existing primary care providers is an imperative for the county and the region. This project will redesign our processes to enhance our patients experience when accessing primary care in our facilities thus increasing the value of the care for our patients.

- **Need for the Project:** The need for this project is to ensure that with the successful completion of our Category 1 Pass 1 project, Expanding Access to Primary Care, the value of that care is enhance and improved to the point that our patient's satisfaction reflects the value of that care and investment made in the additional access.

- **Target population:** The target population is all our patients and families. Approximately 38% of our gross revenues are either Medicaid, self-pay or indigent, so we expect they will benefit from the redesign of our current processes. We currently serve the county of Deaf Smith with a population of approximately 19,500. The target population of 7,410 that includes Medicaid, self-pay and indigent patients will benefit greatly through increasing value by improving our patient's experience when utilizing our services.

- **Category 1 expected patient benefits:** This project seeks to provide an additional value to our patients by increasing HCAPHS scores as well as developing and improving surveys for all our departments that currently aren't surveyed. The increase in patient experience in DY4 and DY5 will be respectively 3% and 6%.

- **Category 3 outcomes:** IT-6.1 Our goal is to improve overall health status for our patient population. Determined baseline patient health status will improve 2% in DY4 and 5% in DY5 thus creating more value for our patients.

Project Title: 2.4.1 Implement processes to measure and improve patient experience

Performing Provider: Hereford Regional Medical Center/133544006

RHP Unique Identification Number: 133544006.2.2 – "PASS 3b"

Project Components: 2.4.1.a-d

Project Description: This project will implement processes to measure and improve our patient's experiences while utilizing our services. This project will not only help address deficiencies in our current HCAHPS scores, but will also track patient satisfaction across all of our services from the admission process through discharge. Survey technology will be identified and utilized to identify our patient's expectations for timely, patient-centered, continuous, and coordinated care regardless of type of insurance. The survey technology will be certifiable and will be conducted by an independent survey vendor. That vendor will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures. At the completion of the 5-year waiver period, patients utilizing the services provided by the Hereford Regional Medical Center will have a redesigned patient experience that not only has improved the quality of the care but also the value of that care. The project goal is to identify and improve patient satisfaction through the redesign of the patient experience. Further project goals are to more directly increase HCAHPS scores to acceptable state and national levels. A minimal increase of 5 to 10% improvement in overall HCAHPS score is expected and an increase of at least 5% will be expected for all other departments within our organization.

Patient centered training will be provided to all employees as well as introducing information to our patients that will allow them to monitor our progress throughout the project using visual as well as digital boards. Patient satisfaction surveys will be implemented for all departments and service lines and staff will be trained and empowered to more directly address the needs of our patients.

An executive will be appointed to be accountable to head a new committee charged with tracking and improving patient satisfaction. The committee will consist of organizational leaders, managers and employees and their charter will be to implement and coordinate initiatives identified through patient satisfaction surveys as well as other informational processes (HCAPHS, CG CAHPS, complaints, Thank You notes, etc.). Service excellence for our patients is what this committee's strategic plan will be. Patient satisfaction and the importance of service excellence will be integrated into employee training not only for new employees, but also for all current employees employed by the organization.

The main challenge of this project is the organization has never before attempted to implement an organizational service excellence project solely aimed at improving our patient's experience. 100% of staff will have to be trained and retrained over the course of the project to achieve the overall project goals of improving our patients experience and how we can best address our patient's expectations. This project will take years to fully implement because of the complete culture change that will be needed by our organization.

By redesigning and enhancing primary care to improve our patient's experience when they utilize our facilities, we will bring additional value to our patients . This project will help ensure a robust primary care sector in Deaf Smith County and the region as a whole that improves patient satisfaction. The main community need of Region 12 is a severe primary care provider shortage, this project will make sure that the primary care provided in Deaf Smith county is patient centered, continuous and coordinated care.

Starting Point/Baseline: The baseline we will utilize is the most up to date HCAHPS scores (1/1/2011 through 12/31/11). They are as follows:

	HRMC	Texas Average	National Average
Nurse Communication	71%	78%	77%
Doctor Communication	80%	83%	81%
Patients help quickly	62%	67%	65%
Pain Controlled	65%	72%	70%
Medication Communication	58%	64%	62%
Rooms kept Clean	63%	73%	72%
Room Quiet at Night	56%	67%	59%
Discharge Instructions	80%	83%	83%
Overall Rating	59%	71%	69%
Recommend the Hospital	52%	72%	70%

For all other departments, survey methods and tools will be identified and implemented to determine baselines for all other departments.

Rationale: The rationale for this project is to improve our patient's experiences while seeking care at our facilities. The state's healthcare transformation goal is counting on a robust primary care sector to improve quality, reduce costs and improve patient satisfaction. This project in conjunction with our Pass 1 project (Expanding Primary Care Access) will create a culture of change within our organization that will improve the quality of care, the timeliness of care and the information our patients receive. Along with the training of all employees in providing service excellence to our patients, the needs and expectations of our patients will be more directly and adequately met. The overall approach will involve all stakeholders both internal and external and the information gathered will be used to redesign our current patient experience to improve quality, reduce costs and improve patient satisfaction. We have never implemented an overall district and hospital wide redesign of our system to improve our patient's experience.

DY2 milestone and metrics will focus round the organization aspects of developing a culture within our organization that improves and enhances our patient's satisfaction. For our organization to create a positive patient experience through service excellence by our staff, an executive responsible for that process will be appointed. That executive will head a steering committee that will be comprised of organization leaders, employees, and patients to implement and coordinate improvements in our patient satisfaction/experience. We will begin to integrate patient experience into our performance measures as well as developing a training program on patient experience for all our employees.

The DY3 milestones and metrics will be centered around the aspects of integrating the new training and processes into our culture. For our employees to fully understand the vision of improving patient satisfaction, all employees will need to be integrated into that process through new organizational learning training. That process will be fully implemented with not only 100% of all new employees receiving that training, but all employees. Also, in year 3 our organization will develop a plan to obtain patient experience information for departments that currently do not have survey tools in place. For our organization to move forward, all departments encompassing all employees, will be surveyed. As for the existing survey tools such as HCAHPS, workgroups will be formed by the steering committee to address identified targets within the survey.

In DY4, the milestones and metrics are reflective of the process improvements implemented in years 2 and 3. Improvement in HCAPS scores will be at least three percent over the baseline show for the 2011 scores. The 10 HCAHPS survey questions have been averaged and the 2011 baseline is 64.6%. Also, that information will be displayed for all patients and families to view as well as suggestions on what we can do better. These display boards will be available in lobbies located in the hospital building and MOB. Employees will also be able to view the progress of the improvement efforts to stay informed thus increasing communication throughout the organization. Also, specific patient experience objectives will be built into our employee job descriptions to better communicate with our employees about our patient's expectations.

Finally, in year 5 the improvement in HCAHPS scores of baseline will increase an additional 3% over baseline. We will also be seeking improvement of all the other departments that currently do not have survey tools of at least 5% over the baseline that will be established in year 3. The rationale behind these improvement targets is the ultimate measure of the success for the culture change we are implementing. An evaluation of the results will be performed in year 5 to ensure that the process is successful and that continued improvement can be expected. Periodic review is an integral part of performance improvement.

Target Population & Zip Codes:
Residents of Deaf Smith County – 79045, 79025, 79035, 79092, 79098

Community Need Identification Number:
Redesign to Improve Patient Experience – 2 - CN.1, CN.2, CN.5, CN.6

CN.1	Severe primary care provider shortage, wait time, expense, lack of insurance, access to care	BRFSS data, Focus groups, survey, DSHS
CN.2	Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.	BRFSS data, survey, focus groups. DSHS data
CN.5	Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung lung disease. Travel to Urban areas for care is difficult.	BRFSS Data
CN.6	Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam.	BRFSS data, survey, focus groups.

Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction - IT 6.1 (5) patient's overall health status/functional status. (Standalone Measure).
The Category 3 outcome is directly related to this Category 2 project in the respect that the outcome for this project will not only allow more individual access to primary care but will also accentuate the value of that care through a more patient centered experience. The Category 3 project will develop and enhance the value of the Category 2 project through patient satisfaction scores thus ensuring our patients benefit and value for their time.

Also, with the increase of input through the Category 2 project the overall quality of care experienced in the clinic will increase our patients overall health status thus decreasing healthcare costs.

Relationship to other Projects: The relationship of this project to our other projects is directly targeted to expanding access to primary care and making sure that access is value added through patient satisfaction, reduction of costs through appropriate utilization and timely care. Our Pass 1 Category 1 project (133544006.1.1) is to Expand Primary Care Capacity and our Pass 2 Category 1 project (133544006.1.2) Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care are designed to provide enhanced services to our patients in a clinic setting to improve patient quality and satisfaction. This project will bring all other departments into the process of improving patient satisfaction and process improvement throughout the total organization. A culture change will be implemented to more directly address the expectations of our patients. These projects working together will not only provide to our patients expanded access to primary care, but will also guarantee the value of that access to our patients of that care.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project addresses overall waiver goals by aiming to assure the patients being seen and treated by Hereford Regional Medical Center receive high-quality and patient centered care through ensuring their input into the processes of care provided regardless of insurance type. All patient types will receive equal input into what HRMC does well and what HRMC needs to improve upon. This project will also achieve waiver goals of developing a well-trained and patient oriented staff. The redesign of our processes will, in the end, improve quality, reduce costs and improve patient experience.	**4**
Addresses Community Need(s)	Relative to our other proposed projects of expanding primary care capacity and expanding the number of community cased settings where behavior health services are delivered, this project will ensure the value to our patients as well as to Medicare, Medicaid and ultimately our patients the value of the care they have received. Through this project process improvements will be made as a result of the cultural change our organization will undertake. Improvements will be centered on our patients needs and expectations which will ultimately lead to be outcomes for our patients.to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at	**3**
Project Scope/Size	Relative to your other proposed projects, this project works hand in hand with our other Category 1 projects as well as our Category 3 projects. The value of increasing access to both primary care and behavioral health care is only realized with the care have value. That's what this project will ensure for the patients of Deaf Smith County. The scope of this project is by far the largest of all of Hereford Regional Medical Center's projects. The reason for this determination is the fact that all employees and all of our patients will have the opportunity to have input into how our patients experience can be improved.	**5**
Project Investment	The overall cost of the project will be reflective in the amount of time our employees spend working on patient experience/satisfaction process highlighted in the process improvements below as well as the cost of providing survey's departments both internal and external for all departments. The human resources required will be substantial setting up the committees, revamping employee training to educate our employees about the importance of good patient satisfaction. Survey tools will need to be identified and those tools will need to be purchased for the departments that currently don't have survey tools presently. Also the equipment needed for the successful implementation of the project will need to be determined as well as updating our website to communicate our patient experience scores externally.	**4**

133544006.2.2 "PASS 3B"	*2.4.1*	*2.4.1 A-D*	*Implement processes to measure and improve patient experience.*
Hereford Regional Medical Center			*133544006*
Related Category 3 Outcome Measure(s):	*133544006.3.4*	*IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Appoint an executive accountable for experience performance/service excellence. **Metric 1 [P-1.1]:** Documentation of an executive assigned responsibility for experience performance. **Goal:** Appoint Executive. Data Source: Organizational Chart. **Milestone 1 Estimated Incentive Payment:** $101,297.50 **Milestone 2** [P-3]: Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient experience/service excellence. **Metric 2 [P-3.1]:** Documentation of committee proceedings and list of committee members. **Baseline/Goal:** Establish committee.	**Milestone** 5 [P-4]: Integrate patient experience into employee training. **Metric 5 [P-4.1]:** Percent of new employees who received patient experience training as part of their new employee orientation. **Goal:** 100% **Data Source:** Human Resource Records. **Milestone 5 Estimated Incentive Payment:** $149,869.66 **Milestone 6 [P-9]:** Develop a plan to roll out a regular inquiry into patient experience in organizations currently without one, or for areas with one, in a new area of organization, which currently does not collect patient experience information. **Metric 6 [P-9.1]:** Submission of a patient experience implementation/expansion plan. **Goal:** Develop and submit patient	**Milestone 8 [P-6]:** Include specific patient experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. **Metric 8 [P-6.1]:** % employees who have specific patient experience objectives in their job descriptions. **Goal:** 100% **Data Source:** Job Descriptions, staff performance metrics **Milestone 4 Estimated Incentive Payment:** $144,095 **Milestone 9 [I-16]:** Improve patient satisfaction/experience scores. **Metric 9 [I-16.1]:** Percent improvement of patient satisfaction scores for HCAHPS. **Baseline Average from 2011:** 64.6% **Goal:** 67.6% **Data Source:** HHS.gov Hospital	**Milestone 11 [I-16]:** Improve patient satisfaction/experience scores. **Metric 11 [I-16.1]:** Percent improvement of patient satisfaction scores for HCAHPS. **Baseline Average from 2011:** 64.6% **Goal:** 70.6% **Data Source:** HHS.gov Hospital Compare **Milestone 11 Estimated Incentive Payment**: $ 237,390 **Milestone 12 [P-13]:** Perform a mid-course evaluation of the results of improvement projects/make necessary adjustments and continue implementation. **Metric 12 [P-13.1]:** Submission of evaluation results. **Goal:** Complete and submit evaluation results. **Data Source:** Evaluation write-up.

133544006.2.2 "PASS 3B"	***2.4.1***	***2.4.1 A-D***	***Implement processes to measure and improve patient experience.***	
Hereford Regional Medical Center			***133544006***	
Related Category 3 Outcome Measure(s):	***133544006.3.4***	***IT-6.1***	***Percent Improvement over baseline of patient satisfaction scores***	
Data Source: Meeting minutes, agendas, participation lists, and list of committee members. **Milestone 2 Estimated Incentive Payment:** $101,297.50 **Milestone 3 [P-5]:** Integrate patient experience into performance measures. **Metric 3 [P-5.1]:** Documentation of specific patient experience objectives into management work plans and measures of performance, such as internal quality controls or performance dashboard. **Baseline/Goal:** Establish reports, policies and procedures. **Data Source:** Performance Report, reporting policies and procedures or department work plans, documentation of incentive in employee performance plan. **Milestone 3 Estimated Incentive Payment:** $101,297.5 **Milestone 4 [P-15]:** Develop a training program on patient experience.	experience implementation/expansion plan. **Data Source:** Plan **Milestone 6 Estimated Incentive Payment:** $149,869.66 **Milestone 7 [P-11]:** Orchestrate improvement work on identified experience targets. Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. **Metric 7 [P-11.1]:** Submission of implementation plan. **Goal:** Setup workgroups **Data Source:** Implementation plans. **Milestone 7 Estimated Incentive Payment**: $149,869.66	Compare **Milestone 9 Estimated Incentive Payment:** $144,095 **Milestone 10 [I-18]:** Develop regular organizational displays of patient experience data and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. **Metric 10 [I-18.1]:** Number of organization-wide displays about the organizations performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. **Goal:** 2 Visual Displays and 1 digital on website. **Data Source:** Displays and internal communication. **Milestone 10 Estimated Incentive Payment:** $144,095	**Milestone 12 Estimated Incentive Payment:** $118,695

133544006.2.2 "PASS 3B"	***2.4.1***	***2.4.1 A-D***	***Implement processes to measure and improve patient experience.***
Hereford Regional Medical Center			***133544006***
Related Category 3 Outcome Measure(s):	***133544006.3.4***	***IT-6.1***	***Percent Improvement over baseline of patient satisfaction scores***

Metric 4 [P-15.1]: Submission of training program materials. **Goal:** Submit Training materials. **Data Source:** Training materials. **Milestone 4 Estimated Incentive Payment:** $101,297.50			
Year 2 Estimated Milestone Bundle Amount: $405,190	Year 3 Estimated Milestone Bundle Amount: $449,609	Year 4 Estimated Milestone Bundle Amount: $432,285	Year 5 Estimated Milestone Bundle Amount: $356,085
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,643,169			

Project Option: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Performing Provider: Lynn County Hospital District / 094180903

RHP Unique Identification Number: 094180903.2.1

Project Components: 2.9.1.a-e

Provider: Lynn County Hospital District is a 24-bed Critical Access Hospital located 35 miles from the RHP, serving approximately 6,000 residents.

Intervention: This project will implement a patient navigator who will oversee the hospital district's indigent program.

Need for the Project: Currently there is no indigent care coordinator and the clients in this county are not identified and therefore not benefitting from services available.

Target Population: The target population is the county residents who are under-insured, non-insured or below poverty level. Approximately over 30% of the county falls within these measures, so we expect our project could impact as many as 1500 county residents. With the Medicaid restrictions, Lynn County has many clients who fall between the cracks and are not eligible for state or federal funding.

Category 2 expected patient benefits: This project expects to increase our indigent clients by 15 client s each project year. We currently have about 60 clients on the program. Our goal is to have 135 clients at the end of the project who are enrolled and receiving primary care from a designated healthcare provider.

Category 3 outcomes: IT-9.2 Our goal is to provide these patients with ongoing medical care with a specified PCP who will oversee their care in the clinic setting and prevent excessive use of the Emergency Department with non-emergent cases. LCHD will offer free vaccines, free blood pressure monitoring, free clinic visits, free diagnostic services and inpatient services as needed.

Project Option: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Performing Provider: Lynn County Hospital District / 094180903

RHP Unique Identification Number: 094180903.2.1

Project Components: 2.9.1.a-e

Project Description: Lynn County Hospital District plans to employ a patient navigator who will oversee the indigent population of the district and identify the uninsured of the county. Our plan is to increase the number of indigent patients cared for by the district and include these patients with a provider so the ER visits decrease. LCHD plans to identify uninsured patients from Emergency Room visits and Clinic visits, help process them for the indigent program and then establish them with the LCHD clinic so they can receive continual well visits and hopefully lower the ER visits and maintain a higher level of wellness. At this time, our only indigent clients are funneled through the business office and this is only done as last resort. This employee will be able to actually visit homes or clinics to help the patients qualify for the program. Our goal is to increase our indigent clients each year by 10%. It is difficult to identify patients that need healthcare assistance as they many times are seen thru the ER and do not get evaluated by staff that are qualified to determine indigent. Many of the county residents seek treatment at other hospitals because they don't know what services are available at LCHD. We currently face challenges and issues due to the many uninsured residents that need healthcare and don't even know where to start since they are uninsured. We feel that this project will help address this issue because we will navigate them through the system: primary care, follow up, etc. Region 12's goal is to address as many of the needs identified in the region's needs assessment. This project addresses multiple community needs: CN.1, CN.2, CN.4, CN.6, CN.7. Our 5 year expected outcome is to have identified the majority of uninsured people living in our community, enroll them in the navigation program and have measured success in the improvement of their overall health.

Starting Point/Baseline: LCHD currently has approximately 60 clients on the Indigent Program.

Rationale: LCHD chose this project because we have such a low income uninsured population that needs primary healthcare. We now have 2 mid-level practitioners that would be able to provide primary care for this population if we can identify the clients and get them enrolled in the program. Our county has four small towns with 2 of the 4 being closer to Lubbock and one being closer to Lamesa. We need to funnel these patients away from surrounding community hospitals and bring them to our hospital and clinic. LCHD receives tax money from the constituents and we feel we need to give back to the community and this is a product that we can offer. Our project will begin with hiring a staff member to oversee the project. This patient navigator will become a confidant to the clients and give them the resources for primary healthcare and a person that the indigent client can contact for assistance.

With over 36% of the county residents below poverty and uninsured, the patient navigator will be continually processing clients for the program and keeping the current enrollees with primary care. At this time our indigent program is done if a client requests some assistance. Our new program will be designed to go find the clients that need assistance. Many of these clients will be former Medicaid clients that no longer have Medicaid coverage. Adding a minimum of 15 clients each year with an increase of 20 the fifth year will more than double the number enrolled and serviced at this time plus will include the whole household.

Project Components:

d) *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* Patients using the emergency department for primary care services, patients without a designated PCP or medical home, and patients with social or economic barriers to accessing primary care will be offered navigation services. Patient Navigators will create social services notes in the EHR that will be associated with the patients' medical record by medical record number. These notes will include sections on reason for services, assessment, subsequent referrals and follow-up activities. Patients will be provided a copy of these notes as well.

   Our navigator will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health, community outreach, and chronic disease management.

e) *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* We plan to hire a Patient Navigator with a background in community health, social services, mental health, or public health with experience providing direct care to disadvantaged populations.

f) *Connect patients to primary and preventive care and d) Increase access to care management and/or chronic care management* – We have two primary care providers that will provide care for our patients enrolled in the program. The navigators will be in frequent communications with them regarding patient's care.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement* –Our RHP will have a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. We will also have an ongoing open forum within our region throughout the year. We will use this information to conduct quality improvement on our project.

Unique Community Needs ID numbers the project addresses:

CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
CN.2 - Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.
CN.4 - High incidence of obesity, diabetes mellitus and heart disease.

CN.6 - Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam
CN.7 - Insufficient maternal and prenatal care, especially the first trimester teen pregnancy, high percentage of unmarried mothers

Related Category 3 Outcome Measure(s): IT-9.2 ED Appropriate Utilization – 094180903.3.1
With this project, Lynn County Hospital District will monitor the indigent population with a chosen provider who will oversee their primary health care. These clients will be seen on a regular clinic visits instead of using the Emergency Room for non-emergent cases. As the clients are provided more well care the ER visits will slow down. This continuity of care will improve the health of the low-income population as they will get on-going care instead of waiting until their condition exacerbates. This will provide the right care at the right place at the right time therefore decreasing the amount of ER visits. This project will ensure that the uninsured or low income population will be assured quality healthcare on an on-going basis and the clients will be assigned a primary care provider that they will have access to. The enrollees will also have a patient navigator who will act as a advocate for their care and their healthcare needs.

Relationship to other Projects: Our region is focusing on reaching out to the low-income population and providing them with well-care benefits and with services such as behavioral health that they have not been channeled to in the past. Many of Lynn County residents drop in at regional emergency rooms for care when they should be seeking that care at LCHD and our intent is to educate them to continue with the same providers for continuity of care. LCHD has chosen Cat 2.9.1 project with RHP Unique Identification Number: 094180903.2.1 and we are not doing a Category 4 project.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	• Our project will ensure our indigent patients will have continuity of care and be assigned to a provider for their healthcare. • Our project will ensure our indigent patients will receive well checks and ongoing healthcare before their conditions worsen and they need ER care • Our project will ensure that the Patient Navigator will be a constant coordinator between indigent patients and provider • Our project will ensure low cost office clinic visits as opposed to high cost ER visits • Our project will definitely impact our goal of identifying and processing the indigent patients of Lynn County and giving them on-going well care with an assigned provider. Our project definitely impacts the Medicaid eligible and uninsured patients of Lynn County. • This project should increase our indigent numbers by 50% at the end of the project which should decrease the number of uninsured in our county • There is strong evidence that clients regularly seen by one provider overseeing their care is much more effective than clients not having a primary care provider	**5**
Addresses Community Need(s)	Lynn County Hospital District is addressing the highest percentage of uninsured of Lynn County. Our county has a higher rate of uninsured than the majority of the rest of the region so we are focusing on identifying, processing and educating those people. Our project definitely impacts the Medicaid eligible and uninsured patients of Lynn County. This project should increase our indigent numbers by 50% with at least 135 clients enrolled in the program at the end of the project which should decrease the number of uninsured in our county. There is strong evidence that clients regularly seen by one provider overseeing their care is much more effective than clients not having a primary care provider	**5**
Project Scope/Size	This project will be a major impact to our community and county. Our plan is to increase the indigent population by 10% each project year. We plan to host educational sessions, provide health fairs, flu vaccine clinics yearly and increase patient well checks to the clinic. Our Family Nurse Practitioners who staff the clinic are excited to be involved in this project. At this time, this clinic is sliding scale and this will reach a larger part of the community. We expect a decrease dramatically in the emergency visits from the county uninsured.	**5**
Project Investment	Our patient navigator will reach out to the uninsured thru follow-up clinic or emergency room visits and at this time we plan to hire one full-time Spanish speaking employee to be housed at the Family Wellness Clinic for overseeing the indigent program. This project will need an office area with a computer and telephone. This employee will be able to travel the county for education and will need an expense account for travel. This employee should have a strong desire to ensure the indigent clients feels comfortable and will be an advocate with the providers for the on-going care of the clients.	**5**

094180903.2.1	2.9.1	2.9.1.a-e	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
Lynn County Hospital District			**094180903**
IT-9.2 ED Appropriate Utilization	**094180903.3.1**	**IT-9.2**	**ED Appropriate Utilization**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-1 Conduct a needs assessment to identify the patient population to be targeted with the Patient Navigator program **Metric(s): P-1-1** Provide report identifying county residents who have been to Emergency Dept for non-emergent care who are non-insured and need financial assistance. **Data Source:** Needs assessment document **Milestone 1 Estimated Incentive Payment: $**21,919 **Milestone 2: P-2** Establish/expand a health care navigation program to provide support to the patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education	**Milestone 3: P-3** Provide care management/navigation services to targeted patients and increase the enrollment. **Metric(s): P-3.1Increase the number of indigent enrollees by 15 clients.** **Baseline/Goal:** baseline = 60 enrollees. Goal: Increase indigent enrollees into navigation program to 75 **Data Source:** Patient Navigator enrollment records **Milestone 3 Estimated Incentive Payment:** $50,814	**Milestone 4: 1-6** Increase numbers of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: I-6.2** Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED. To increase the indigent program by 15 clients. **Baseline/Goal:** baseline is 0. Goal is to refer 20% of our patients enrolled in the navigator program and increase the program by 15 clients. **Data Source:** Patient Navigator Logs and E.H.R. **Milestone 4 Estimated Incentive Payment:** $51,339	**Milestone 5: 1-6** Increase numbers of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: I-6.2** Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED and add 20 new clients to the indigent program. **Baseline/Goal:** baseline is 0. Goal is to refer 20% of our patients enrolled in the navigator program and add 20 new clients **Data Source:** Patient Navigator Logs and E.H.R. **Milestone 5 Estimated Incentive Payment:** $43,986

094180903.2.1	**2.9.1**	**2.9.1.a-e**	**Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care**
Lynn County Hospital District			**094180903**
IT-9.2 ED Appropriate Utilization	**094180903.3.1**	**IT-9.2**	**ED Appropriate Utilization**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Metric(s): P-2.1 Number of people trained as patient navigators, number of continuing education sessions for patient navigators **Data Source**: workforce development plan for patient navigator recruitment, training and education **Milestone 2 Estimated Incentive Payment:** $21,919			
DY 2 Estimated Milestone Bundle Amount: $43,838	DY 3 Estimated Milestone Bundle Amount: $50,814	DY4 Estimated Milestone Bundle Amount: $51,339	*DY5 Estimated Milestone Bundle Amount: $43,986*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $189,977			

Project Option: 2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors.
Performing Provider / TPI: Memorial Hospital / 094121303
Project Identification number: 094121303.2.1 – "PASS 2"
Project Components: 2.11.1.a-d

- **Provider:** Seminole Hospital District, dba, Memorial Hospital is the sole healthcare provider in rural Gaines County, Texas. Memorial Hospital is a Critical Access hospital serving a population of approximately 17,500. The District as a whole provides healthcare services which include Home Health, Hospice, Provider Assistance, Assisted Living, Long-term Care, a wellness center, two provider based clinics as well as general hospital acute care services.

- **Intervention:** Memorial Hospital will implement a process to track and reconcile patient medications and to educate patients regarding appropriate use, expected outcomes and interaction of medications.

- **Need for the Project:** We have a high population of uninsured and Medicaid patients many of which have chronic diseases which can be managed through an appropriate medication regimen. We have seen that many of these patients struggle understanding the need for medications and the need to take them as prescribed.

- **Target Population:** . This project will target emergency room and acute care patients who are diagnosed with a chronic disease relating to high blood pressure, specifically including diabetes and chronic heart failure, who are taking multiple medications and whose health care is funded through Medicare or Medicaid programs or who are unfunded.

- **Category 2 expected patient benefits:** The project seeks to provide medication management to 95% of the targeted patient population, . We estimate this to impact 3,000 patients in DY 3, DY 4 and DY 5 combined.

- **Category 3 outcomes:** IT.1.7 is to increase the number of patients whose blood pressure is adequately controlled by TBD%.

Project Option: 2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors.
Performing Provider / TPI: Memorial Hospital / 094121303
Project Identification number: 094121303.2.1 – "PASS 2"
Project Components: 2.11.1.a-d

Project Description:

Memorial Hospital proposes to implement a process to conduct medication management to ensure that the targeted patient population receives the appropriate medications and education to effectively manage their illness/chronic illness.

The overarching goal is to provide the appropriate medications and patient education to effectively manage an illness and as a result, improve patient health outcomes. The potential areas for improvement include; patient education, reduction in healthcare cost due to poor medication management and improved patient outcomes. This project will consist of developing the systems and processes to track and reconcile patient medications and to educate patients regarding appropriate use, expected outcomes and interaction of medications. The required core project components include: a) develop criteria and identify targeted patient populations, b) develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error, c) conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes and d) conduct quality improvement for project using methods such as rapid cycle improvement. These core components provide the jumping off point for Memorial Hospital in developing and implementing this project. A core team including nurses and physicians will develop criteria, identify target populations, and develop education tools. Quality Assurance will conduct root cause analysis and quality improvement reviews. This project will target emergency room and acute care patients who are diagnosed with a chronic disease relating to high blood pressure, specifically including diabetes and chronic heart failure, who are taking multiple medications and whose health care is funded through the Medicare or Medicaid programs or who are unfunded. Given the utilization rates at Memorial Hospital, this project is expected to significantly impact Medicare, Medicaid and uninsured patients. The 5 year expected outcome is to provide medication management to 95% of the identified target patient population. We estimate this to impact 3,000 patients in DY3, DY4 and DY5 combined.

Starting Point/Baseline*:*

Memorial Hospital does not have a specific process in place to provide focused patient education and medication management. Therefore the starting point and baseline will be 0.

Rationale:

Analysis of the top ten diagnosis at Memorial Hospital revealed that chronic illnesses comprise 47% (1,983) to be chronic illness related. Further analysis revealed that 83% of these patients were funded through Medicare, Medicaid or were uninsured. In Gaines County, approximately 18.7% of the population is below the poverty line. Approximately 40% of our county residents are uninsured. These populations present a challenge to providing quality health care in our community. Individuals from these various groups often have multiple chronic conditions requiring numerous medications to effectively manage the condition. With multiple chronic conditions, the risk of complications related to medication mismanagement; inappropriate use, inappropriate dosage or drug interaction, increases significantly. This project will be a new initiative for Memorial Hospital presenting the opportunity to analyze effective use of medications in the targeted population. The results of this project will provide information to determine whether medication regimens are effectively managing the chronic illnesses of our patients. In addition, this project will provide information to ensure that the patients are using medications as prescribed. Medication management can reduce health care costs by reducing hospital admissions or complications related to ineffective treatment of chronic diseases. Memorial Hospital will address each of the require components in this project option 2.11.1 a) develop criteria and identify targeted patient populations, b) develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error, c) conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes and d) conduct quality improvement for project using methods such as rapid cycle improvement. Process milestones will include P-1 – Implement a medication management program and/or system including metric P 1.1 and milestone P-2 – Develop criteria and identify targeted patient populations including metrics P-2.1, P-2.2 Improvement measures will include milestone I-9 – Manage medications for targeted patients and metric I-9.1. These milestones and metrics are each relevant to the development and implementation of this project.

Given the socio-economic status of our community, chronic diseases, such as diabetes, COPD and CHF are prevalent. Adult and childhood obesity and diabetes are prime health concerns in our area. According to the Centers for Disease Control, Gaines County age adjusted, diagnosed diabetes patients is 9.2%. While slightly lower than the State percentage of 9.8%, complications from lack of primary and preventative diabetic care are commonly seen in our hospital. In our local community needs assessment, developed in April 2012, chronic disease management and prevention was expressed as a significant need. In the regional community needs assessment, chronic illnesses, including diabetes, were considered an urgent need. As noted in both local and regional community needs assessments, chronic illnesses are significant health concerns in our area. Appropriate management of medications used to control these illnesses will reduce healthcare costs and improve health outcomes for patients locally and within the region. This project is related to the regional community need CN.4, noted as an urgent need.

Related Category 3 Outcome Measure(s):

The Category 3 Outcome Measure selected to support his project is OD1 – Primary Care and Chronic Disease Management. Process milestones will include P-1, P-3, P-4 and P-5, all of which will be necessary to develop and successfully implement this project. Improvement Targets beginning in DY 4 and DY5 will include IT-1.7 – Controlling high blood pressure. This outcome measure tie directly with the project as medications are used to manage chronic illnesses related to high blood pressure. The development of a medication management process and subsequent annual monitoring of patients on persistent medications, works hand-in-hand to ensure effective treatment of the chronic diseases of the targeted population.

Relationship to other Projects:

This project, 094121303.2.2.1.1, is related to Category 1, Implement a Chronic Disease Management Registry (1.3), Enhance Interpretation Services and Culturally Competent Care (1.4) and Category 2, Expand Chronic Care Management Models (2.2). Each of these projects addresses management of chronic illnesses, management which is typically provided through an appropriate medication regimen.

Relationship to Other Performing Providers' Projects in the RHP:

Our project meets regional goals to develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region. This project will help the region transform health care to a patient-centered, coordinated delivery model that improves patient satisfaction and health care outcomes. Our project meets a critical need identified in our regional needs assessment and our local needs assessment.

Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project effectively achieves the triple aim of assuring patient receive high –quality, patient-centered care, in the most cost effective ways, by truly focusing on the individual patient and helping him/her to manage their illness through appropriate medication use avoiding the costly care associated with unmanaged chronic illness. Research conducted by the World Health Organization, Agency for Healthcare Research and Quality and Centers for Medicare and Medicaid Services all indicate that the ratio of dollars spent on medications to the positive impact on the costs and health outcomes is substantial. Given the utilization rates at Memorial Hospital, this project is expected to significantly impact Medicare, Medicaid and uninsured patients.	**5**
Addresses Community Need(s)	Medication Management significantly addresses the local and regional community need related to chronic diseases (CN.4). Chronic diseases are prevalent in this area due to the socio-economic status of many of the area's residents. Patient education and effective medication management have the potential to move the dial towards healthier patients and cost-effective care. Relative to Memorial Hospital's other project, Category 1 – Primary Care and Chronic Disease Management, medication management ties as an important component to disease management.	**5**
Project Scope/Size	This project provides the opportunity to improve patient health outcomes and prevent unnecessary utilization of emergency room and/or acute care services. Medication management is expected to affect 3,000 patients during the final 3 years of this project.	**5**
Project Investment	To successfully implement and sustain this project requires funds for educational materials, systems to capture and analyze data electronically and personnel to provide education and project quality improvement review. It is expected that the initial investment will be significant due to the need to capture data electronically. Initial investment will also include education of existing staff regarding implementation of this project. Maintenance of the project will require one employee to conduct quality improvement review and existing staff to provide patient education.	**4**

094121303.2.1-"PASS 2"	*2.11.1*	*2.11.1.A-D*	**Implement interventions that put in place the teams, technology, and processes to avoid medication errors.**
Memorial Hospital Gaines County			***094121303***
Related Category 3 Outcome Measure(s):	***094121303.3.2***	***IT-1.7***	***Controlling high blood pressure.***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1- P-2.-Develop criteria and identify targeted patient populations. **Metric P-2.1.-** Establish evidence based criteria for medication management planning in target population based on assessment of population needs. **Baseline/Goal:** Baseline will be 0. Goal will be completion of P-2 milestone. **Data Source:** Written criterion for target population and program participation. **Milestone 1 Estimated Incentive Payment***:* $23,939.50 **Milestone 2 - P-1.-** Implement/expand a medication management program and/or system. **Metric P-1.1** -Program elements, documentation of program, including people, processes and technologies. **Baseline/Goal:** Baseline will be 0. Goal will be completion of P-1 milestone **Data Source:** Written medication management plan including workflow for providers. **Milestone 2 Estimated Incentive Payment***:* $$23,939.50	**Milestone 3 – I-9 –** Manage medications for targeted patients. **Metric 1 – I-9.1 –** Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management. **Baseline/Goal:** Baseline will be 0. Goal will be 700 patients contacted or receiving medication management. **Data Source:** Paper or electronic health record. **Milestone 3 Estimated Incentive Payment** $53,128	**Milestone 4 – I-9 –** Manage medications for targeted patients. **Metric 1 – I-9.1 –** Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management. **Baseline/Goal:** Baseline will be 0. Goal will be 1,000 patients contacted or receiving medication management. **Data Source:** Paper or electronic health record. **Milestone 5 Estimated Incentive Payment:** $ $51,081	**Milestone 7 – I-9 –** Manage medications for targeted patients. **Metric 1 – I-9.1 –** Increase the number of patients (meeting criteria for chronic condition) contacted or receiving management. **Baseline/Goal:** Baseline will be 0. Goal will be 1,300 patients contacted or receiving medication management. **Data Source:** Paper or electronic health record. **Milestone 7 Estimated Incentive Payment:** $42,077
Year 2 Estimated Milestone Bundle Amount: $47,879	Year 3 Estimated Milestone Bundle Amount: $53,128	Year 4 Estimated Milestone Bundle Amount: $51,081	Year 5 Estimated Milestone Bundle Amount: $42,077
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $194,165			

Project Option: 2.6.2 Establish Self-Management Programs and Wellness Using Evidence-Based Designs
Performing Provider Name/TPI: Muleshoe Area Medical Center/ 130877708
Unique Project ID: 130877708.2.1

Provider: Muleshoe Area Medical Center is a 25-bed Critical Access hospital located in Muleshoe, Texas. It is the only hospital in Bailey County, serving a 835 square mile area and a population of approximately 7300. The hospital district includes a small portion of Parmer County. MAMC also serves patients from Lamb County, as well as Curry and Roosevelt Counties in New Mexico. The next nearest hospital is 30 miles away.
Intervention: This project will establish a wellness program directed at the entire hospital district. . Through community awareness events, physician referrals, word of mouth, and various methods of media communication we plan to broaden the scope and involvement of the community served by the hospital district, especially the lower income, Medicaid and indigent populations. This will be a new initiative for the hospital district.
Need for the project: Bailey County, along with most of Texas, is seeing a huge increase in obesity-related diseases and the need for primary care to treat these diseases. Without intervention the adult obesity rate is projected to grow to 55-60% by the year 2030. When combined with the difficulty of attracting new primary care providers to a rural area, this could result in an inability to provide adequate care for the entire hospital district.
Target population: The target population is all residents of the hospital district. Since Bailey County has been designated as a low-income area, many of district residents will fall within 200% of Federal Poverty Guidelines. A large number of these families are served by Medicaid or are uninsured and are served by local indigent or charity programs. We plan to reach other Medicaid or indigent persons by directing the community awareness events toward topics of interest tied with incentives for attendance. We expect to educate 75 in DY4 and 100 in DY5 and that approximately 50% of the participants will be uninsured, Medicaid, or indigent.
Category 2 expected patient benefits: The project seeks to provide education for developing a healthier lifestyle and opportunities to participate in group activities to increase activity levels. Community awareness and participation activities, such as a community garden, will be directed at children, the elderly and low-income families. By encouraging the interaction between senior citizens and children a wealth of practical information about wise living can be transferred from an aging generation to younger individuals. Participation levels will be determined by those who attend an event and voluntarily provide survey information. Our expectation is to reach a mimimum of 100 participants in DY5.

Category 3 outcomes: The project seeks to raise the perception of quality of life for the participants and encourage a more pro-active approach to one's health outcomes. An evidence-based Quality of Life Survey will be used to rate the physical and emotional aspects of one's life. The baseline will be established in DY2 and our objective is to see and increase in average rating of 10% in DY4 and 15% in DY5.The

ultimate desired outcome, though unmeasureable, is to reduce the need for primary care by reducing the incidence of obesity-related disease.

Project Option: 2.6.2 Establish Self-Management Programs and Wellness Using Evidence-Based Designs
Performing Provider Name/TPI: Muleshoe Area Medical Center/ 130877708
Unique Project ID: 130877708.2.1

Project Description:
Muleshoe Area Medical Center proposes to disseminate information describing and demonstrating ways to eat healthier & become more physically active through the distribution of educational materials, quarterly community presentations, and access to group activities designed to combat obesity and reduce the occurrence or severity of obesity-related chronic diseases. **What will it accomplish?** The Community Wellness Program is designed to address the overwhelming issue of obesity and the occurrence of related chronic diseases. Obesity is a factor in virtually all diseases that have a higher occurrence in low-income areas. Lifestyle and cultural issues are factors that contribute to the predisposition or likelihood for a patient to become overweight or obese. With the overriding idea of "an ounce of prevention is worth a pound of cure", our intention is to meet the need of the region by disseminating educational material and information about relevant community activities that will aid in the improvement of overall health. Learning and applying new behaviors related to cooking practices, fast food, sugary soft drinks, eating habits and physical activity are essential to living a healthier lifestyle. Changing the habits and learned behaviors of a lifetime is a huge challenge. However, by using a two-pronged approach of education and practical application, the project intends to bridge the gap between unutilized information and putting tools in the hands of patients in order to make long-term changes in behavior that will result in a healthier lifestyle. This is the area in which we believe we can have the greatest impact to avoid obesity-related diseases. **What are the potential areas of improvement?** By addressing these issues in the earlier stages, before a patient becomes morbidly obese, diseases such as type 2 diabetes, heart disease, high blood pressure, breathing problems and some kinds of cancer may be limited in severity or avoided altogether. Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers only information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. As patients begin to lead healthier, more active lives, the perception of a better quality of life emerges. A recent study in the Journal of Sports and Exercise demonstrates a direct and almost immediate correlation between physical activity and a general sense of well-being and improvement in mood. By being proactive in regard to one's health, a sense of control over one's life emerges. Increased perception of well-being tends to have a positive impact on every facet of life. Working together as a community toward a common goal brings citizens more in touch with friends and neighbors in the community with similar needs and goals. This, in turn, leads to community pride and an increased community spirit. **Who will be part of the healthcare team implementing the project?** A committee of 5 to 7 key hospital employees and community health workers will be designated to

oversee the project. A Project Coordinator will be appointed to assure that the requirements of the project are being met. **What will their responsibilities be?** The full committee will assess evidence-based wellness programs, determine implementation timelines, and review the effectiveness of the program. The Project Coordinator will be primarily responsible for day-to-day implementation of the project and record keeping and will report to the full committee. Community awareness activities, such as health fairs, healthy-cooking demonstrations, and instruction will be conducted by community health workers on a quarterly basis. Community projects, such as a community garden, will encourage the integration of different age demographics with different needs and abilities. The cooperative interaction of these age groups will be productive and educational for all those who participate. **How many facilities or clinics will be impacted by the project?** MAMC hospital and 2 clinics operated by the hospital district will be directly impacted by our project along with other strategic locations throughout the community. **Describe the flow of the process. Step by step.** This program will utilize culturally appropriate methods of communication including English and Spanish language communications and printed materials. Social media and text-messaging will reach into areas that may not be reached by more traditional methods. Community activities will also be announced to the public by newspaper and local public access television. Printed materials will be made available at MAMC hospital and 2 clinics operated by the hospital district along with several other strategic locations throughout the community. Messaging will be conducted in conjunction with local phone service providers. Community awareness activities will be designed and conducted on a quarterly basis by community health workers. Community projects will be designed to incorporate as many residents from different demographics to an increase the exchange of ideas, education, and skills. Friendly competitions along with other incentives will be designed to increase participation throughout the community. A committee of 5 to 7 key hospital employees will be designated to oversee the project. The milestones are designed to reflect the Plan-Do-Study-Act cycle. Milestone 1 is the planning stage where we consider the evidence-based programs available to us and determine which will most closely meet the need of the population and the hospital setting. Milestone 2 is the Do or implementation stage as we put the program into operation. Milestone 3 is the study phase as we measure the success of the program and determine what changes or modifications can be made to improve the process and/or results. Finally, Milestone 4 is the final assessment of the success of the program by determining the level of participation by the target population. **Who will your project target?** Although everyone can benefit from a healthier lifestyle, our target population will be residents of the hospital district. **Define your population in detail.** HRSA has designated Bailey County as a low-income county, with a Hispanic population of 47.3% and an overall White population of 66.68%, according to the 2010 US Census, with an undetermined amount of overlap within these two demographics. The Journal of the American Medical Association, 2012, lists Mexican-Americans at an obesity rate of 40.4%, followed closely by non-Hispanic Whites at 34.3%. Therefore, the population is at great risk of developing obesity-related diseases. **Tie to CAT 3 outcome measure population.** Our Category 3 Outcome IT-10.1 is designed to measure improvement in quality of life. The target population for IT-10.1 will be those who voluntarily participate in the community awareness activities and exercise activities provided through the Wellness Program. Improving the perception of one's quality of life will have an impact on the mental, emotional, and physical

aspects of the whole person. A positive outlook leads to pro-active behaviors that affect all areas of one's life and collectively the interactions of a society at every level. **Goals and Relationship to Regional Goals:** The goal of this project is to educate the public on the benefits of healthy living. In addition, we will attempt to engage) participants in practical healthy behaviors before disease appears. This goal is tied to the RHP 12 Needs Assessment as a critical need (CN.4). By making available educational materials, events, and the facilities to enable the at-risk population to actively adopt a healthy lifestyle we will facilitate a new approach to preventive health care.

Project Goals: 1. Disseminate printed educational materials to the entire community/county in order to reach high-risk individuals 2. Increase participation in community awareness programs 3. Increase participation in community activities that educate and implement healthy behaviors. This project meets the following regional goals: 1. Transform health care delivery from a disease-focused model of episodic care to a patient-centered prevention model that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system 2. Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges: This first challenge is communication with the lower-income segment of the target population. To get educational information or notice of community events to this demographic will take some creative thinking. The second and larger challenge for this project will be to effect true, lasting changes in the eating behaviors and activity levels of the overweight and obese. As is evidenced by January enrollment rates in gyms and weight loss programs, a New Year's resolution may get many individuals involved in behavior-changing activities. However, there is generally a large attrition rate as the masses discover that it is not as simple as snapping the fingers or taking a pill. Establishing an inviting environment, issuing challenges, creating friendly competitions between groups, and reinforcing participation and achievement with incentives and awards are a few of the ways to keep the enthusiasm high and foster long-term participation.

5-Year Expected Outcome for Provider and Patients: The five-year goal is to educate, encourage, and provide opportunities for the population to live healthier lifestyles with an increased perception of quality of life for the patient and reduced or stabilized cost to the Hospital District for the medical care associated with uninsured, low-income patients with potentially preventable chronic diseases. We expect to reach an minimum of 100 participants by DY5.

Starting Point/Baseline: Starting point is zero and increase in participation in DY4 and DY5 will be measured in numbers of participants during those years.

Rationale: We selected this project because of the high occurrence of obesity and related diseases, such as type 2 diabetes, heart disease, asthmas and COPD, hypertension, and cancer. HRSA has designated Bailey County as a low-income county, with a Hispanic population of 47.3% and an overall White population of 66.68%, according to the 2010 US Census, with an undetermined amount of overlap within these two demographics. The Journal of the American Medical Association, 2012, lists Mexican-Americans at an obesity rate of 40.4%, followed closely by non-Hispanic Whites at 34.3%. Without intervention, the problem of obesity is projected to rise to alarming rates in the future. According to a 2012 report by The Robert Woods Foundation, if obesity continues on the current growth trajectory, by 2030, Texas will have an adult obesity rate of 55-60%, showing a 90-100% increase. Medical and economic costs of the growth rate would be devastating to this area. This has been determined to present a critical need (CN.4) to this region in both the area of providing health care and also the cost to the patient and the region at large. According to the RHP 12 Needs Assessment Summary, in Amarillo over 60% were found to have "excessive body weight (overweight 32%, obese 28.4%) compared to 54.4% in 2007. Increasing obesity mirrors nationwide trends. Physical inactivity and diet are the major contributing factors according to surveys in both the rural and urban areas. Nationwide studies show the incidence is increasing." Bailey County has a population of approximately 7300. If we assume the county has a similar percentage, then an estimated 4380 are overweight or obese. Our objective is to embark on a campaign to empower the targeted population to make more educated health related choices regarding an active lifestyle and better management of eating habits. By providing opportunities for the target population to participate in organized and/or individual activity and to gain knowledge about healthier dietary practices, the target population has a greater likelihood of making good choices. An atmosphere of community support and encouragement, along with tangible incentives will aid in the process and bring about positive results for those who choose to participate. The improvement targets in DY4 (75 participants) and DY5 (100 participants) were chosen because there is no baseline for determining percentages and this is a projection of the numbers we hope to reach and educate toward constructive change in behavior.

Project components: Quality improvement for this project will be assessed by successive Plan-Do-Study-Act cycles. Areas to be identified and studied will include participation levels, communication methods and the associated attendance at community awareness events, and efforts to broaden the scope of the project to include participation from the entire hospital district. The greatest challenge will be the engage the disabled, , and very low-income populations. Various communication methods will be utilized and assessed. Modifications in methodology based on "lessons learned" will be implemented as the process highlights areas of need for change. The process milestones and metrics have been chosen to track the steps of choosing and implementing an evidence-based wellness program community at large. The improvement milestones and metrics are designed to measure the impact on the community from the standpoint of voluntary participation. More concrete measures of disease control may be difficult if not impossible to assess as a direct result of the project. The long-term effects of the program may not become evident for

many years. We believe that voluntary participation has the greatest opportunity to produce lasting change in the target population. By educating this audience in ways to preserve good health and providing cost effective ways to increase activity, we are addressing RHP 12's expressed need to reduce obesity-related diseases, thereby reducing the ever increasing need for primary care. Nothing of this kind or scope has been attempted previously in this area.

Unique community need identification numbers the project addresses:

- CN.4 - High incidence of obesity, diabetes mellitus and heart disease
- CN.10 - High prevalence of asthma and care issues
- CN.3 - Poor insurance support or uninsured
- CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care

Related Category 3 Outcome Measure(s): IT-10.1 Quality of Life – the American Psychological Association, Dec 2011, draws a significant link from physical activity and mood boost, alleviation of anxiety and depression, and even the ability to avoid disease. Because mind and body are so linked, it is impossible to improve one without improving the other. A recent study in the Journal of Sports and Exercise states that undergraduate students reported an improved mood connected to physical activity. The CDC states, "Participation in health promotion activities. . .allows individuals to develop knowledge, self-management and coping skills as well as build a social support network. . .these skills can facilitate adopting healthy behaviors in the short-term and lead to changes in the physical, mental, and/or emotional health in the long-term". Low-income patients are less likely to join a gym, hire a personal trainer, or seek out a weight-loss program because of the associated cost. However, if a program is provided at low or no cost to the community, these same patients may choose to participate. Improvement in quality of life may take on many characteristics and will vary from person to person. The survey to be used to measure the improvement in Quality of Life is SF-36. This survey most directly relates to the areas of improvement in one's perception of well-being that are being addressed in this project.

Relationship to other Projects: . 130877708.1.1. Primary Care Expansion is designed to meet the current and expanding future needs for Primary Care.

Relationship to other Performing Provider Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects. **Project Valuation:**

Criteria	Narrative	Score

Achieves Waiver Goals	While this project does not necessarily directly address the health care infrastructure or the quality of the care delivery system, it does however address the issue of improving outcomes while containing cost growth. Bailey County has been determined to be a low-income county, with overlap in the demographic area; the target population will be educated in the area of overall health and well-being, which is a step in preventing chronic disease issues that affect the target population.	**4**
Addresses Community Need(s)	According to the RHP 12 Community Needs Assessment, obesity is of great concern to the medical community. Related diseases are also a constant, growing concern. By addressing the core issues before a patient develops a chronic disease related to obesity, we have the opportunity not only to preserve the good health of the patient, but also to lower the need for medical attention, and, therefore, lower costs to the patient and/or the hospital district. Since the cost of chronic care to a low-income patient is often transferred to a larger regional hospital, this project may also have an extended impact to other medical facilities throughout the region and/or state.	**5**
Project Scope/Size	Through multiple methods of communication, such as social media, advertising, flyers, etc., the target population will be contacted about the project, once we have started the program and have achieved a baseline of hospital district employees from which to build upon. Programs are available through which current hospital staff members, as well as possible outside personnel, will be trained in specific nutritional and health/fitness programs in order to better serve the community while keeping costs low, both to the participants and the hospital district.	**5**
Project Investment	The investment of personnel hours, both voluntary and paid, will be the high priority of the project. There will be many hours spent in putting the project together, as well as establishing forms of communication and efforts to contact the target population. There are future plans to purchase equipment necessary to furnish a 'gym' or fitness center to enable the participants to get full value and results from the program. There will be multiple methods of encouraging participants to begin and maintain a healthy lifestyle, including health fairs, healthy cooking options/recipes/demonstrations, etc. This effort may require that we hire an employee fulltime to facilitate the program. Funding for this project will come primarily from MAMC with small donations from the community. Estimated cost for the project is $120,000 for DY2 through DY5.	**4**

130877708.2.1	2.6.2	N/A	Establish Self-Management Programs and Wellness Using Evidence-Based Designs
Muleshoe Area Medical Center		**130877708**	
Related Category 3 Outcome Measure(s):	**130877708.3.1**	**IT-10.1**	**Quality of Life**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-1]: Conduct an assessment of health promotion programs that involve community health workers at local and regional level. Metric 1: [P-1.1]: Data Source: Documentation of assessment and summary of findings Estimated Milestone 1 Incentive Payment: $ *102,826*	Milestone 2: [P-3]: Implement, document, and test an evidence-based innovative project for target population. Metric 1: [P-3.1]: Baseline/Goal: Document implementation strategy and testing outcomes Data Source: Documentation of implementation TBD by MAMC Estimated Milestone 2 Incentive Payment: $ 119,189	Milestone 3: [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1: [I-8.1]: Increase numbers of target population reached Goal: 75 individuals reached Estimated Milestone 3 Incentive Payment: $ 120,420	Milestone 4: [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1: [I-8.1]: Increase numbers of target population) reached Goal: 100 individuals reached Estimated Milestone 4 Incentive Payment: $ *103,173*
DY 2 Estimated Milestone Bundle Amount: $ 102,826	DY 3 Estimated Milestone Bundle Amount: $ 119,189	DY4 Estimated Milestone Bundle Amount: $ 120,420	*DY5 Estimated Milestone Bundle Amount: $ 103,173*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $445,608			

Project Option: 2.4.1 – Implement processes to measure and improve patient experience.
Performing Provider / TPI: Ochiltree Hospital District / 112704504
Project Identification Number: 112704504.2.1 – **"PASS 2"**

Project Components: 2.4.1.a-d

Project Description:

- Provider:

Ochiltree Hospital District (OHD) is a 25-bed hospital in Perryton, TX, estimated population 9,065 in the northernmost county seat located in Ochiltree County, Texas estimated population 10,530. OHD also serves the surrounding counties: Lipscomb County, Texas; Hansford County, Texas; Hemphill County, Texas; Texas County, Oklahoma and Beaver County, Oklahoma. OHD had 7,443 in-patients days and of those 375 were Medicaid and 1,948 were Medicare.

- Intervention(s):

This OHD project will adopt a model for improved patient-caregiver communication, develop and deliver a training and behavior change curriculum tailored for inpatient nurses, and incorporate standards for communication into annual nursing competency evaluations.

- Need for the project:

Over time, implemented projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care.

Target population:

The target population is both impatient and outpatient. This will be based on how many patients we served each year. This project will enhance patient care by improving communication between nurses and our patients, especially the socially disadvantaged and those with language barriers.

- Category 1 or 2 expected patient benefits: The project seeks to improve nurse and patient communication to provider better healthcare.
- Category 3 outcomes: IT-6.1 Our goal is to increase our patient satisfaction by 5% by DY5 after we have set up HCAHPS and have established our baseline rates in DY3. OHD would like to setup and start the HCAHPS for our hospital and CG CAQH for our clinic to track patient satisfaction, in doing this OHD will be using the same IT-6.1.

Project Option: 2.4.1 – Implement processes to measure and improve patient experience.
Performing Provider / TPI: Ochiltree Hospital District / 112704504
Project Identification Number: 112704504.2.1 – **"PASS 2"**
Project Components: 2.4.1.a-d

Project Description:

In anticipation of the moving to a value base purchasing case model and the requirement to report HCAHPS data, OHD will provide comprehensive training to all staff to improve the patient care experience. OHD will also select a vendor that will enable us to track statistically valid data.

Goal:

Ochiltree General Hospital's overall aim is to create an environment in which patients feel safe, listened to and empowered. Our DSRIP project goal is to improve inpatient experience by strengthening the communication skills of our nurses. Nurses are the glue which holds the entire care team together, so engaging nurses' commitment and creativity in the overall patient experience project is a critical early step.

The five year goals are to:

- Ensure that reports on patient experience are available monthly and widely disseminated throughout the organization.
- Train and evaluate 85% of permanent inpatient nurses in communication skills competencies.
- Improve nurse communication scores on HCAHPS patient experience survey by 12% over 2015 baseline by the last quarter of DY14.

Challenges/issues:

Ochiltree General Hospital serves a highly diverse population in terms of language, ethnicity, cultural beliefs and practices, as well as prior experiences with the health care system. Trust is the basis for establishing a strong patient-provider alliance that is the foundation for improved health outcomes, and good communication is the key to trust. The challenge at OGH is to standardize principles of communication for all patients while at the same time finding a way to personalize the message based on the needs of each patient, and to ensure that all staff are skilled communicators.

The inpatient nursing staff are the front line providers of compassion, care and advocacy for acutely ill patients. Nurses have the power to encourage greater patient activation, which ultimately may lead to improved health outcomes. Better communication skills can enhance nurses' effectiveness, and create an overall better experience for patients in the hospital.

5-year Expected Outcome for Performing Provider and Patients:

Major delivery system redesign solution proposed: OHD will adopt a model for improved patient-caregiver communication, develop and deliver a training and behavior change curriculum tailored for inpatient nurses, and incorporate standards for communication into annual nursing competency evaluations.

Relationship to Regional Goals:

Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Starting Point/Baseline Data:

Currently OHD uses a twelve (12) year old in house process of obtaining patient satisfaction evaluations. Those evaluations do not reflect patient perceptions of how well their doctors communicate. New measures would help to address this situation.

Rationale:

The project option chosen by OHD is very critical to its community and its ability to provide services needed by the community. In project 2.4.1, OHD will implement processes to measure and improve patient experience by a) organizational integration and prioritization of patient experience, b) data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience, c) Implementing processes to improve patient's experience in getting through to clinical practice, and d) develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures. In doing this, OHD will show process milestones of P-1, Appoint an project manager accountable for experience performance, P-15, Implement a training program to improve nurse-to- patient communication and design curriculum and education plan, and P-6, Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them.

Unique community need identification numbers the project addresses:
CN.1 – Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.

Related Category 3 Outcome Measures:

IT-6.1 – Percent improvement over baseline of patient satisfaction scores.
Unique RHP outcome identification number(s): 112704504.3.1
Outcome Measure Description:
IT-6.1 – Percent improvement over baseline of patient satisfaction scores.

1. How well their doctors communicate.
    a. Numerator: Percent improvement in targeted patient satisfaction domain
    b. Data Source: Patient survey
    c. Denominator: Number of patients who were administered the survey

Reasons/rationale for selecting the outcome measures:

Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Relationship to other performing provider projects and plan for learning collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	By implementing customer focused communications training, we believe that this will serve to improve the patient-centered care. We also believe that through more effective communication, our patients will better utilize the health care delivery system, resulting in cost savings. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties. We will see improvements in our healthcare system through improved communication and more cost effective utilization of our services. Patient-focused communications training skills and evaluations for nursing staff further develop and maintain a coordinated care delivery system. Improved communication skills will serve to improve patient care outcomes and patient satisfaction scores. These improvement will improve patient outcomes while containing cost growth	5
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	3
Project Scope/Size	This project will reach all segments of our patient population, including our Medicaid and Uninsured population. This is especially important due to the issue of some in this population having limited education or language barriers. This project will enhance every patient interaction in our health organization. This project will provide training to all nursing staff employed in OHD.	3
Project Investment	This is a substantial financial investment to our organization. We estimate the cost of this project to be $60,000 per year. This project is a multiyear initiative that will integrate into our culture through specific employee job descriptions and annual evaluations. Because of the changes expected in Value Based Purchasing, and the effect that it has to the organization through reimbursement, this is a high priority project.	3

112704504.2.1 – "PASS 2"	2.4.1	2.4.1.A-D	Implement processes to measure and improve patient experience.
Performing Provider Name: Ochiltree Hospital District			112704504
Related Category 3 Outcome Measure(s):	112704504.3.2	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance. **Metric 1**: [P-1.1] Documentation of an executive assigned responsibility experience performance. **Goal:** Create new position for executive responsible for experience performance. **Data Source**: Org Chart or Job Description.	**Milestone 2** [P-15]: Develop a training program on patient experience. **Metric 1:** [P-15.1] Submission of training program materials. **Goal**: Implement a training program to improve nurse to patient communication and design curriculum and education plan. **Data Source:** Training materials.	**Improvement Measure 3** [I-X]: Complete training of 85% of permanent nursing staff on the communication model and standards. Metric 1: [I-X.1] Numerator: number of nurses trained Denominator: total number of permanent employed inpatient nurses. **Milestone 4 Estimated Incentive Payment $ 35,879**	**Milestone** [P-6]: Formal evaluation of communication skills competencies will be completed for 85% of permanent inpatient nurses as part of their annual evaluation. Include specific and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. **Metric 1:** [P-6.1] Metric% employees who have specific patient and/or employee experience objectives in their job description and/or work plan. **Numerator**: Number of competency assessments successfully completed/ **Denominator**: Total # permanent nurses. **Data Source:** Job description, staff performance metrics.

112704504.2.1 – "PASS 2"	2.4.1	2.4.1.A-D	Implement processes to measure and improve patient experience.
Performing Provider Name: Ochiltree Hospital District			112704504
Related Category 3 Outcome Measure(s):	112704504.3.2	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $33,630	Year 3 Estimated Milestone Bundle Amount: $37,317	Year 4 Estimated Milestone Bundle Amount: $35,879	Year 5 Estimated Milestone Bundle Amount: $29,555
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $136,382			

Project Option: 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
Performing Provider Name/TPI: Parmer Medical Center/137343308

Unique Project ID: 137343308.2.1

PROJECT Components: 2.2.1.A-E

- **Provider:** Parmer Medical Center (PMC) is a 25-bed Critical Access hospital located in Parmer County, Texas. PMC is the only hospital in the county and serves a population of 10,269 scattered over 880.78 square miles.
- **Interventions:** The project will implement a Care Management Team to ensure proper access to care, appointment scheduling, and to reach patients early in the disease process and when they are at risk of leaving the care of Parmer Medical Center. Once recruited, patients will receive follow-up phone calls, communication, education, and support from team members to ensure that patients continue treatment, medication management, and follow-ups.
- **Need for the Project:** Over the past 10 years, the number one admitting diagnosis to PMC is Congestive Heart Failure and other chronic diseases. Historically, patients with chronic disease are seen in the general clinic population and are monitored by our physicians. No special team focus or outside resources have been utilized to manage the disease process or to emphasize a change in lifestyle. Wellness measures are not the focus of our treatment plans and prevention measures are secondary to treatment
- **Target population:** Our target population is the patients in our service area with chronic diseases or who are pre-disposed to a chronic disease. 37% of adults aged 18-64 are without insurance according to the 2010 County Health Rankings (http://www.countyhealthrankings.org/node/2842/3/archived-data/2010). Our Rural Health Clinic sees an average of 1055 patients each month. Of those patients, approximately 82 are uninsured (12%) and 21 are Medicaid (3%)
- **Patient Benefits:** Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. By DY3, 10 staff (including providers) will be trained I chronic disease care management model.
- **Category 3 outcomes measures:** From 2005 - 2010, 369 adult residents of Parmer County were hospitalized with a chronic disease. According to County Health Rankings, 111 hospitalizations were preventable. Our goal is to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. Patients with a diagnosis of Diabetes type 1 or 2 will see their HbA1c reduced .

Project Option: 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
Performing Provider Name/TPI: Parmer Medical Center/137343308

Unique Project ID: 137343308.2.1

PROJECT Components: 2.2.1.A-E

Project Description:
***Parmer Medical Center proposes to expand Chronic Care Management Models*.**

The project would improve effective management of chronic conditions and ultimately improve patient clinical indicators, health outcomes and quality as well as reduce unnecessary acute and emergency care utilization. The Chronic Care Management Program will provide for a collaborative, multi-disciplinary team that may include but not be limited to Providers, Licensed Nurses, Dietician, Physical Therapist (PT) and other Rehab personnel as needed, Certified Health Coach (HC), Case Manager (CM), Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers.

Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on an assessment of patients' risk of developing complications, comorbidities or utilizing acute or emergency services. These chronic health conditions may include diabetes, congestive heart failure, chronic obstructive pulmonary disease, among others, all of which are prone to co-occurring health conditions and risks.

Chronic Care Management models are needed in rural areas - specifically models which take a community-wide problem-solving focus. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million.[28] There are 62 million Americans currently residing in rural areas. It is estimated that 20 percent of the rural population is uninsured and this number is projected to increase to 25 percent by 2019. The need for increased access to care and insurance coverage is especially crucial for rural populations because they receive less preventive care and have higher rates of all chronic diseases than their urban counterparts (Bailey, 2010). 2009 Health Currents Report lists Parmer County with a population of 9,720 with 55.80 percent of the population being Hispanic. In 2008, there were 92 deaths in Parmer County. Of those 92 deaths, 35 or (38 percent) were attributed to cardiovascular disease. 20 percent of the deaths were due to cancer; 10% due to Diabetes.

The CCM team will ensure proper access to care, appointment scheduling, and will use targeted outreach strategies and health education to reach patients early in the disease process and when they are at risk of leaving the care of Parmer Medical Center.

[28] http://www.hhsc.state.tx.us/1115-docs.pdf

Once recruited, patients will receive follow-up phone calls, communication, education, and support from team members to ensure that patients continue treatment, medication management, and follow-ups.

Target zip codes: 79035 and 79325. We propose to target zip codes in Parmer County with the poorest chronic outcomes.

Goals and Relationship to Regional Goals:

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on a an assessment of patients' risk of developing complications, comorbidities or utilizing acute or emergency services.

Project Goals:

- Increase the number of patients participating in a chronic care management program.
- Decrease hospital admissions related to chronic disease
- Decrease unnecessary ED visits

This project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Chronic disease management initiatives use evidence-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. The program leverages the existing Parmer Medical Center infrastructure to meet the need for enrollment in the Chronic Care Management Program with the goal of improving the poor outcomes currently exhibited in Parmer County.

Challenges:

The primary challenge for this project will be to engage and build trust with patients. Creating and implementing a Chronic Care Management Model is a new initiative for Parmer County. Historically, patients with chronic disease are seen in the general clinic population and are monitored by our physicians. No special team focus or outside resources have been utilized to manage the disease process or to emphasize a change in lifestyle. Wellness measures are not the focus of our treatment plans and prevention measures are secondary to treatment. Introducing a new concept and style of disease management, cultural competency training

and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement and ensure program success.

5-Year Expected Outcome for Provider and Patients:

The implementation of a Chronic Care Management Model will lead to the reduction in reactive rescue care including ED and inpatient care and improve disease specific metrics. Introducing a new concept and style of disease management, cultural competency training and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement and ensure program success.

Starting Point/Baseline:

Currently, a patient chronic disease management program does not exist for patients at Parmer Medical Center. The baseline number of participants as well as the number of participating providers begins as 0 in DY2.

Rationale:

Promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings. There are many definitions of "chronic condition", some more expansive than others. We characterize it as any condition that requires ongoing adjustments by the affected person and interactions with the health care system. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive- responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible. To speed the transition, Improving Chronic Illness Care created the CCM, which summarizes the basic elements for improving care in health systems at the community, organizational, practice and patient levels. Evidence on the effectiveness of the CCM has recently been summarized.

Establish a healthcare program and provide support to the targeted population who are most at risk thus supporting the goals of RHP 12. There are 62 million Americans currently residing in rural areas. It is estimated that 20 percent of the rural population is uninsured and this number is projected to increase to 25 percent by 2019. 2009 Health Currents Report lists Parmer

County with a population of 9,720 with 55.80 percent of the population being Hispanic. In 2008, there were 92 deaths in Collingsworth County. Of those 92 deaths, 35 or (38 percent) were attributed to cardiovascular disease. Our facility will establish training for providers and a multi-disciplinary team will assist in diminishing the deficiencies in the current delivery system. Encourage providers to follow established best practice guidelines, coordinating care and offering follow-up to ensure positive outcomes, and building patients who are better informed and able to assist the providers in managing their chronic diseases.

Project Components:

Through the Expand Chronic Care Management Models, we propose to meet all required project components.

A) *Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system*- This will be accomplished by providing training to a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project. These providers can navigate the patient through the health care system, education process and build patients who are better informed and able to assist the providers in managing their chronic diseases.

B) *Ensure that patients can access their care teams in person or by phone or email*- Patients that are enrolled in chronic care management will be given access to contact their health care team. This contact will be in the form of phone numbers and email.

C) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources- Implementing this project will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. The multi-disciplinary team will initiate patient education as well as group and self-management support while utilizing available community resources.

D) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions*- Community and individual education, health and lifestyle coaches and other healthcare team members can assist in chronic disease management and encouraging compliance with treatment and preventative plans.

E) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations*- To achieve this component we will review chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions

between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care.

Unique community need identification numbers the project addresses:

- CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.2- Lack of mental health services, inability to gen an appointment, lack of insurance, need to use ERs for initial contact
- CN.3- Poor insurance support or uninsured
- CN.4- High incidence of obesity, diabetes mellitus and heart disease
- CN.10- High prevalence of asthma and care issues

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently, a Chronic Care Management program does not exist for patients at Parmer Medical Center. Our system offers case management services, but this is typically only accessible to admitted patients. The initiative will improve access for targeted patients while helping the system reach capacity for treating patients with chronic diseases.

Related Category 3 Outcome Measures:

OD-1 Primary Care and Chronic Disease Management; IT-10 Diabetes Care: HbA1c poor control (>9.0)

Patients with a diagnosis of Diabetes type 1 or 2 will see their HbA1c >9.0 reduced**Reasons/rationale for selecting the outcome measures:** Chronic disease management outcome data related to selected Category 3 outcomes are described above and are all identified as Rural Healthy People 2020 objectives and ARHQ quality indicators by the federal government. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care.

Relationship to other Projects: This project's focus on cultural competency and disease management for patients with chronic diseases ties to our RHP goals by assisting in transforming health care delivery from an episodic disease focused model of care to a patient-centered, coordinated care management delivery system that improves patient outcomes and satisfaction, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. Related Category 4 measures include potentially preventable admissions measures and readmissions in RD-1 and Patient Satisfaction in RD-4.1.

Relationship to Other Performing Providers' Projects in the RHP & Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Sco
Achieves Waiver Goals	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. The chronic care management model (CCMM) addresses the healthcare needs of all patients regardless of their financial resources. By implementing the CCM Model, we should be able to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population.	
Addresses Communit y Need(s)	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. RHP 12 has identified Expanding Chronic Care Management as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN3- Poor insurance support or uninsured. CN4- High incidence of obesity, diabetes mellitus and heart disease CN10- High prevalence of asthma and care issues RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.3 and CN.4 have been defined as *Urgent Needs*, and CN.10 falls in the category of *Important Need But Less Urgent.* The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.	5
Project Scope/Size	From 2005 - 2010, 369 adult residents of Parmer County were hospitalized with a chronic disease resulting in Parmer County receiving $2,532,586 in charges for those hospitalizations that were potentially preventable if the residents had increased access to care, had cooperated with appropriate healthcare, and had a multi-disciplinary support team to assist in monitoring and managing the chronic disease. Our Rural Health Clinic sees and average of 1055 patients each month. Of those patients, approximately 82 are uninsured (12%) and 21 are Medicaid (3%) We would implement a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project.	4
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Chronic Care Model, so our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all members of our multi-disciplinary staff and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined after establishing our project baseline data	4

137343308.2.1	**2.2.1**	**2.2.1.A-E**	**Expand Chronic Care Management Models**	
Parmer Medical Center			**137343308**	
Expand Chronic Care Management Models	**137343308.3.1**	**IT- 1.10**	**(CHF) Diabetes Care: HbA1c poor control (>9.0)**	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-3] Project Planning Develop a comprehensive care management **Metric 1:** [P-3.1] Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. **Baseline/Goal:** Develop program **Data Source**: Program materials Estimated Milestone 1 Incentive Payment: $88,506	**Milestone 2:** [P-2] Project Planning Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care. **Metric 1:** [P-2.1] Increase percent of staff trained **Baseline/Goal:** staff trained/100% staff trained **Data Source:** HR, Training Program materials Estimated Milestone 2 Incentive Payment: $96,555		**Milestone 3: [I**-17] Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally **Metric 1:** [I-17.1] 8 additional patients receive care under the Chronic Care Model for a chronic disease or for MCC **Goal:** 8patients of the Medicaid and uninsured population with chronic diseases will receive care under the Chronic Care Model for a chronic disease or for MCC **Data Source:** EHR, Claims Estimated Milestone 3 Incentive Payment: $96,836	**Milestone 4:** [1-17] Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally **Metric 1:** [[1-17.1] 8 additional patients receive care under the Chronic Care Model for a chronic disease or for MCC **Goal:** an additional 8 (or 50% increase equaling 16) patients will receive care under the Chronic Care Model for a chronic disease or for a MCC **Data Source:** EHR, Claims Estimated Milestone 4 Incentive Payment: $ 79,995
DY 2 Estimated Milestone Bundle Amount: $88,506	DY 3 Estimated Milestone Bundle Amount: $ 96,555		DY4 Estimated Milestone Bundle Amount: $ 96,836	*DY5 Estimated Milestone Bundle Amount: $79,995*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $361,892				

Project Option: 2.4.3 Increase Patient Satisfaction
Performing Provider Name/TPI: Parmer Medical Center/137343308
Unique Project ID: **137343308.3.2 "PASS 3b"**

-Provider: Parmer Medical Center (PMC) is a 25-bed Critical Access hospital located in Parmer County, Texas. PMC is the only hospital in the county and serves a population of 10,269 scattered over 880.78 square miles.
-Interventions: The project will implement a system wide patient satisfaction survey process to measure the patient's perception of and satisfaction with their care experience in our facility. The experience may include proper access to care, appointment scheduling, and outreach to patients early in the disease process and when they are at risk of leaving the care of Parmer Medical Center.
-Need for the Project: The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven upward partially by the increase of costly readmissions and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by comprehensive patient questionnaires detailing the patients' satisfaction or dissatisfaction with the hospital's services.
-Target population: Our target population is the patients or patient representatives in our service area who have been admitted, have utilized our Emergency Department, our clinic and/or outpatient services. 37% of adults aged 18-64 are without insurance according to the 2010 County Health Rankings (http://www.countyhealthrankings.org/node/2842/3/archived-data/2010). Our Rural Health Clinic sees an average of 1055 patients each month. Of those patients, approximately 82 are uninsured (12%) and 21are Medicaid (3%)
-Patient Benefits: A system wide patient satisfaction program will improve the knowledge base of providers as well as patients as it relates to the effectiveness and overall success or inefficiencies of our health care system, will assist us in identifying areas to improve care and coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to be involved in having a voice in the environment in which they receive health care.
-Category 3 outcomes measures: When we provide a supportive environment and patients are satisfied with the care that they have received from our doctors, nurses and other health care team then the potential for compliance with the preventive or treatment plan is much more likely. We will measure our effectiveness based on scores from our internal Patient Satisfaction surveys. Surveys will include questions relating to care received from physicians and nurses, the hospital environment and the discharge experience. By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. The patient experience and satisfaction model addresses the healthcare needs of all patients regardless of language, ethnicity or cultural beliefs. By implementing the Patient

Experience Model, we should be able to improve patient satisfaction and promote a healthier population. From 2005 – 2010 369 adult residents of Parmer County were hospitalized with a chronic disease. According t County Health Rankings, 111 hospitalizations were preventable. Annualized, this represents approximately 22 patients. Our goal is to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. Admissions will be reduced by 10 % in DY4 and DY5

Project Option: 2.4.3 – Project Option: Increased patient satisfaction

Performing Provider Name/TPI: Parmer Medical Center/137343308

Unique Project ID: 137343308.3.2 **"PASS 3b"**

Project Description: ***Parmer Medical Center plans to enhance and expand its patient satisfaction Program.***

As a small hospital many services are referred to larger urban providers with the capability to provide a more robust patient experience. At PMC, we are unable to provide patient survey and implement patient experience training due to cost constrains. However, we see this as a valuable tool to progress transformation in our system of care delivery. By implementing and expanding satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care and meet this challenge. By doing so the hospital's goal is to better understand the needs of its unique patient base in order to better care for and provide higher quality of care to those patients. Additionally, a system wide patient satisfaction program will be implemented from the t top down emphasizing its importance including new employee orientation, public reporting of the hospital scores, individual recognition of documented employee satisfaction efforts, and the implementation of needed upgrades based on patient comments. We believe that patient engagement and patient experience is transformational. The surveys utilized will measure and account for education patients about his or her treatment options, how to achieve better health outcomes and how to be more engaged and responsible for their own healthcare.

Target zip codes: 79035

Goals and Relationship to Regional Goals: The goal of this project is to develop and implement a plan to improve the patients' experience of care as an institutional priority. This will be accomplished by implementing new tools to measure the patients' experience and satisfaction. Additionally, the goal is to improve the patient experience by strengthening the communication skills of our employees. So engaging employees' commitment and creativity in the overall patient experience project is a critical early step.

Project Goals:

Improve how the patient experiences the care and the patient's satisfaction with the care provided. The state healthcare transformation is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience. This will require a redesign of primary care to meet the needs of patients for timely, patient-centered, continuous, and coordinated care to enhance access to care regardless of type of insurance. The overall approach to redesigning the patient experience will be centered on cultural change at the organizational level. This will involve the practitioners and staff in the clinic and in-patient setting as well as the patients and their families or caregivers. An organizational strategy will be developed so that entities will manage patient experience and create avenues to implement the strategic plan/vision. Providers' performance will be measured, among other factors, by the extent to which patient experience improves systematically.

Patient experience will be assessed through focused surveys. The architecture for patient focused surveys should be modeled after the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool, which includes the following domains: patients are getting timely care, appointments, and information; how well providers communicate with patients; patients' rating of provider; and assessment of office staff. The Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) survey can be used to assess patient experience in the hospital setting. Certain supplemental modules for the adult survey CG-CAHPS may be used to establish additional outcomes: Health Literacy, Cultural Competence, Health Information Technology, and Patient Centered Medical Home.

These surveys will be mandatory, and will be administered at the end of the medical episode, six weeks after the visit (to avoid recall bias) and six months if no other episode of care intervened.

This project meets the following regional goals:

- Transform health care delivery through a coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:

Trust is the basis for establishing a strong patient-provider alliance that is the foundation for improved health outcomes, and good communication is the key to trust. The challenge at PMC is to standardize principles of communication for all patients regardless of language, ethnicity or cultural beliefs, while simultaneously finding a way to personalize the message based on the needs of each patient, and to ensure that all staff is skilled communicators. Another key challenge will be in ensuring customer participation in the survey and subsequent quality initiative and process.

5-Year Expected Outcome for Provider and Patients:

Primarily this project will be to engage and build trust with patients. Creating and implementing a plan that will standardize principle communication for all patients. Improving patient experience and satisfaction is a new initiative for PMC. Historically, there has not been a plan or project in place that inhabits all staff to focus on patient experience and satisfaction. Introducing this new concept of a standardized patient experience model will involve extensive training for all staff to facilitate patient engagement and ensure program success.

- Ensure that reports on the patient experience are available monthly, disseminated throughout the organization, and results are discussed and included in the process of improvement
- Train and evaluate staff in communication skills competencies.
- Improve score on HCAHPS patient experience survey by TBD% over the 2013 baseline. (TBD after initial surveys are in and baseline established)
- Include the Spanish speaking and the less educated population

Starting Point/Baseline:

Currently, PMC does not have a system wide patient satisfaction survey in place. Therefore we will be developing and implementing this program to include both inpatient and outpatient.

Rationale:

Over time, implemented projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care. At PMC, we are unable to provide patient survey and implement patient experience training due to cost constrains. However, we see this as a valuable tool to progress transformation in our system of care delivery. By implementing and expanding satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care and meet this challenge. By doing so the hospital's goal is to better understand the needs of its unique patient base in order to better care for and provide higher quality of care to those patients.

Metrics and Milestones: Establishing a healthcare program to provide support and satisfaction to our population will enhance the goals of RHP 12. Providing training for all staff will assist in diminishing the deficiencies in the current delivery system encouraging providers, nursing and ancillary staff to provide the best patient experience possible from our facility.

DY2- We will appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance. Provide documentation of an executive assigned responsibility experience performance. DY3- Write and disseminate a patient/family experience strategic plan. Submit a strategic plan and documentation of the dissemination of that plan throughout the organization. DY4- Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data. Develop a new patient experience survey tool or revise and improve the current ones along with documentation of inquiry materials. DY5- Increase the number of patient satisfaction surveys distributed and collected. Increase the number of HCAHPS surveys distributed and collected.

Project Component: Implement an innovative an evidence based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in Category 3, Outcome Domain – 6 Patient Satisfaction.

Unique community need identification numbers the project addresses:

- CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact
- CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult.

- CN.6- Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently our ability to improve is impaired by inadequate tools and data. Parmer Medical Center's commitment to improving the patient's experience of care is embedded in its overall strategic plan. Some areas of our facility use homegrown survey tools that make it difficult to compare and improve performance. 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 patient's experience and satisfaction. In addition, internal display and sharing of data will give staff the tools and information necessary to improve the experience.

Related Category 3 Outcome Measures:
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measures: The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven upward partially by the increase of costly readmission and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by detailed patient questionnaires detailing the patients' satisfaction or dissatisfaction of the hospital's services.

Relationship to other Projects:

This project's focus on patient experience ties to our RHP goals by assisting in transforming health care to a patient centered, coordinated care management delivery system that improves patient outcomes and satisfaction, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. We have proposed Category 2 project is 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases and 2.4.3 Increase patient satisfaction. We feel that if we have a Patient Satisfaction Program in place this will enhance the quality of the Chronic Care Management Model project. Related Category 3 outcome measures are IT-6.1 Percent improvement over baseline of patient satisfaction scores. Related Category 4 measures include potentially preventable readmissions in RD-1 and Patient Satisfaction in RD-4-1.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face to face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Redesign to Improve Patient Experience will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will ensure positive outcomes and will enhance patients' abilities to manage their own illnesses. The patient experience and satisfaction model addresses the healthcare needs of all patients regardless of language, ethnicity or cultural beliefs. By implementing the Patient Experience Model, we should be able to improve patient satisfaction and promote a healthier population. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.	**5**
Addresses Community Need(s)	RHP 12 has identified Redesign to Improve Patient Experience as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: • CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care • CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. • CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult. • CN.6- Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.5 and CN.6 have been defined as *Urgent Needs.*	**4**
Project Scope/Size	We would implement a nationally recognized survey that would capture pertinent data using a patient questionnaire detailing the patients' satisfaction or dissatisfaction of the clinic and/or hospital's services. Once obtaining this data, the facility will conduct quality improvement for the project using methods a rapid cycle improvement process. Activities may include, but will not be limited to, identifying project impacts, "lessons learned," and opportunities to scale all or part of the project to a broader patient population.	**5**

Criteria	Narrative	Score (1-5)
Project Investment	We are a small rural hospital with limited resources. Our Rural Health Clinic sees an average of 1055 patients each month. Of those patients, approximately 82 are uninsured (12%) and 21are Medicaid (3%) Currently our facility does not have a system wide patient experience model, so our investment in a nationally recognized survey, development of program, educating key executive staff and training for all staff members will be costly. Additional equipment purchases and maintenance will be determined after establishing our project baseline data. This project is NOT funded through the collaboration option.	**5**

137343308.3.2 – **"PASS 3b"**	**2.4.3**	**N/A**	**Increased Patient Satisfaction**
Parmer Medical Center			**137343308**
Related Category 3 Outcome Measure(s):	**137343308.3.2**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-1 Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for patient experience performance P-1.1 Metric: Documentation of an executive assigned responsibility experience performance Baseline/Goal: develop program and establish baseline Data Source: Organizational Chart or job description (if percentage of time) *Estimated Milestone 1 Incentive Payment: $61,620*	***Milestone 2:* P-2** **Write and disseminate a patient/family experience strategic plan** **P-2.1: Metric: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization** **Baseline/Goal: Currently we have no plan. We will establish a written plan and educate entire organization** **Data Source: Internal organizational communications, experience strategic plan** ***Estimated Milestone 2 Incentive Payment: $64,353***	*Milestone 3* P-8 Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data. Metric P-8.1 Develop a new patient experience survey tool or revise and improve the current ones. P-8.1 a. Documentation of inquiry materials. Baseline/Goal: develop program and increase patient participation by 10% or 105 patients Current baselineis 0% Data Source: Documentation of inquiry materials *Estimated Milestone 3 Incentive Payment: $ 61,419*	*Milestone 4:* I-X Increase the number of patient satisfaction surveys distributed and collected. Metric I-X.1 Increase the number of HCAHPS surveys distributed and collected Baseline/Goal: Increase patient participation by 5% (or 211 patients) over DY4 baseline Data Source: HCAHPS surveys *Estimated Milestone 4 Incentive Payment: $ 48,780*
DY 2 Estimated Milestone Bundle Amount: $61,620	**DY 3 Estimated Milestone Bundle Amount:** $ 64,353	**DY4 Estimated Milestone Bundle Amount: $** 64,353	**DY5 Estimated Milestone Bundle Amount:** $48,780
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $236,173			

PROJECT OPTION: 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
PERFORMING PROVIDER: PLAINS MEMORIAL HOSPITAL/136142011
UNIQUE PROJECT ID: 136142011.2.1
PROJECT COMPONENTS: 2.9.1.a-e

Provider: Plains Memorial Hospital (PMH) is a Critical Access Hospital in Dimmitt, Texas. PMH offers Emergency Medical Services, Outpatient, Inpatient, and a Rural Health Clinic. We serve Castro County, which has a population of 7,292 residents. PMH is the only provider of acute care services in Castro County.
Intervention: The Patient Care Navigation Program will enable PMH to provide navigation services to patients who are at high risk of disconnect from institutionalized health care. A primary concern is the misuse in the ED; in addition we will attempt to provide education to all at risk patients utilizing the ED. A Community Health Worker (CHW) will be used to connect patients to primary and preventive care in the right setting. This program should reduce the number of non-urgent, non-emergent visits to the ED.
Need for the Project: This is a new project for PMH. We have a population who is in dyer need of being educated in regards to healthcare, available community resources, specialty care after initial physician contact, and right care right setting. The CHW will assist in coordination of care among providers and arrange financial support by assisting with application process for different payer sources such as SSI, Medicaid, Indigent and Charity, etc. The CHW will also facilitate follow up appointments after ED visits and with specialty care when needed.
Target Population: Our targeted populations are those patients who utilize the ED for non urgent, non emergent care, patients without a PCP or medical home, and patients with social or economic barriers to healthcare. We believe that by providing a bridge between these patients and their healthcare we will be able to educate and facilitate right care right setting which will in turn reduce cost to both the patient and the facility. We have approximately 20% self pay which could possibly qualify for indigent, charity or Medicaid but because of the aforementioned barriers do not fill out the paperwork.
Category 2 Expected Patient Benefits: We currently serve 0 patients; the CHW will attempt to enroll 184 or 10% of the identified targeted patients into the Patient Navigation Program in DY 3 and increase this by 5% in DY 4 for a total of 277 or 15%. Our expected benefit to the patient is to navigate, educate and facilitate proper care and treatments.
Category 3 outcomes: IT-9.2 - Right Care Right Setting - Our goal is to reduce the ED utilization by a total of 5% or (9) in DY 4 and an additional 5% for a total of 10% (28) of enrolled targeted patients by DY 5.

PROJECT OPTION: 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
PERFORMING PROVIDER: PLAINS MEMORIAL HOSPITAL/136142011
UNIQUE PROJECT ID: 136142011.2.1
PROJECT COMPONENTS: 2.9.1.a-e

Project Description:
The Patient Care Navigation Program will enable Plains Memorial Hospital (PMH) to provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others.)

A Community Health Worker (CHW) will be used to connect patients to primary and preventive care in the right setting. The project will increase access to care management and/or chronic care management, including education chronic disease self-management. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Goals and Project Relationship to the Regional Goals:
The goal of this project is to use a CHW as a patient navigator to provide enhanced care coordination, community outreach, social support, and culturally competent care to patients in the targeted population. The Patient Navigator will help guide and support these patients through the continuum of health care services throughout their health care plan. The CHW will ensure that patients receive coordinated, timely, and site-appropriate health care services. The CHW may assist in connecting patients to PCP care, as well as diverting non-urgent patient care from the ED to site-appropriate locations.

Project Goals:

- Identify the patient populations to be targeted by the Patient Navigator Program.
- Enroll target patients in the patient care navigation program.
- Establish a healthcare program that provides support to the targeted population who are most at risk of receiving disconnected and fragmented care
- Increase the percentage of enrollment over the duration of the program.
- Decrease non emergent ED use and provide right care in right setting.

- Increase patient engagement through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources.
- Increase the number of PCP referrals for patients without a medical home who use the ED and hospital services.

This project meets the following regional goals:

RHP 12 has identified the project as a one that meets the needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. Specifically, the program directly impacts CN.1, CN.2, CN.3, CN.4, and CN.5. The goal of RHP 12 is to advance the promotion of the health of Americans living in rural communities by identifying rural health priorities, supporting rural health leaders and researchers, and promoting effective rural health programs.

Challenges:

The County, primarily Hispanic, creates challenges, including language barriers with 49% of other language other than English spoken at home is Spanish. We have about 23.3% of the population who live below the poverty level with an average household income of $35,087. PMH averages 220 patients per month through the ED. Approximately 1848 or 70% of these visits are for non-urgent, non-emergent care. They are using the ED to receive primary care services instead of accessing the rural health clinic because of their inability to pay for services. We currently see approximately 29% Medicaid patients in the ED, of which 65%, could be seen in the RHC but choose to be seen in the ED because of the mentality that they have Medicaid so it doesn't matter if it is an emergency or not. The parent of a minor child is usually under the impression that they have the right to be seen and do not understand the financial implications of being seen in one setting versus the other. We also contend with our Charity and Indigent population, about 5% of our ED visits, choosing the ED over the Clinic because it is something they feel entitled to once they have qualified for Charity/Indigent. PMH does feel like our Indigent/Charity ED visits would be higher but the majority stay in self-pay because they will not fill out paperwork. We have to educate our Medicaid, Indigent and Charity population to utilize the RHC for non emergent care so PMH will continue to be around to supply healthcare in the community. In addition, it will be a challenge for the CHW to engage in and build a trusting relationship with the targeted patient population.

5-Year Expected Outcome for Provider and Patients:

The 5-year expected outcome for PMH and our patients is to identify the patient populations to be targeted by the Patient Navigator Program. We hope to enroll at least 15% or 277 of our identified target population into the Patient Navigation Program by the end of DY 4. Our Goal is to reduce the ED utilization by a total of 10% or 28 of the patient's we hope to enroll in the navigation program. This will be measured by the difference in total number of ED visits pre- and post-navigation services. PMH will increase the number of PCP referrals for patients without a medical home who use the ED and hospital services. PMH will focus on all zip codes within our County.

Staring Point/Baseline:
We are currently serving 0 patients with the Patient Care Navigation Program. There is no CHW at this time. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0. We will hire one individual to spearhead the Patient Navigation Program. Our goal is to enroll 15% or 277 of identified targeted patients, frequent non urgent ED users, into the program by the end of DY 5. PMH hopes to reduce the ED usage by a total of 10% or 28 of the identified targeted patients by the end of DY 5.

Rationale:
PMH selected this Category 2 project, 2.9.1, primarily due to the misuse of the ED by patients who desire to use the ED as a place to receive primary care. While determining which project to choose we also identified many other needs in our community that will be addressed with the Patient Care Navigation Program. The Patient Care Navigation Program will enable PMH to address the following community needs based off of the Community Needs Assessment: CN.1, CN.2, CN.3, CN.4, and CN.5.
With the community needs in mind the Patient Navigation Program will assist families in finding and following up with healthcare that is best suited for them with the goal of having right care in the right setting and being cost effective and efficient to both the patient and PMH. The Patient Care Navigation Program will enable PMH to provide navigation services to targeted patients.
PMH is the only provider of acute care services in Castro County which has a population of 7,292 residents. Our Community Needs Assessment tells us that we are very vulnerable population because of ethnic, cultural, economic, geographic, and health characteristics. Our residents are in a group that is at risk for not obtaining necessary medical care, and thus constitutes a potential threat to their health. Without proper education and navigation for our patients we will continue to see a rise in the use of the ED as a first point of contact for patients to healthcare. We then have to be concerned of the patient's lack of follow-up. With a CHW we will have the capability to follow-up with patients and assist them in their additional healthcare needs.
The Patient Care Navigation Program will provide needed healthcare personnel who will be used to connect patients to primary and preventive care in the right setting. The project will increase access to care management and/or chronic care management, including education chronic disease self-management. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.
The CHW will identify the targeted patients, manage the identified patients and work to reduce the cost to treat those patients and help ensure that they are receiving the right care in the right setting. The CHW will identify frequent ED users, which are classified as non-urgent, non-emergent patients and track through the EMR. The CHW will teach the patient to be able to identify what an emergency is and then work with them to address the specific reasons for the ED visit. The CHW will align additional resources as needed which could include but is not limited to financial assistance, transportation, medication assistance, interpretive services,

and access to specialty care. The CHW would also be responsible for follow up on each of the areas identified and assist the patient in being compliant with the health care plan. These measures will help to reduce cost and provide the right care in the right setting. PMH will be able to provide the right care in the right setting, OD-9, IT-9.2, by utilizing the ED in the appropriate manner. The ultimate goal for PMH over the next five years is to reduce ED visits by frequent, non urgent, non emergent patients and to assist patients in finding and following up with the right care in the right sitting.

Project Components:

Through the Patient Care Navigation Program, we propose to meet all required project components.

PMH will utilize our nursing staff and physicians to identify frequent ED users and use navigators as part of a preventable ED reduction program. PMH will train health care navigators in cultural competency. Patients using the ED for primary care services, patients without a designated PCP or medical home, and patients with social or economic barriers to accessing primary care will be offered navigation services. The Patient Navigator will create social services notes in the EHR that will be associated with the patients' medical record by medical record number. The CHW will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health, community outreach, and chronic disease management. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. We plan to hire a Patient Navigator, CHW, with a background in community health, social services, mental health, or public health with experience providing direct care to disadvantaged populations. These individuals will be bilingual, from our community, and experienced in identifying community resources.

The Patient Navigator will connect patients to primary and preventive care and increase access to care management and/or chronic care management – We will have regular contact with area primary care providers for care management services, preventive care, and other educational and social services.

PMH will conduct quality improvement for project using methods such as rapid cycle improvement –We will create a data registry for enrolled patients to facilitate follow-up and effectiveness analysis. Reports will be run weekly by the program and shared monthly with ED staff and participating primary care providers. We will report during monthly meetings with program staff and ED providers how we identify project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project.

Unique community need identification numbers the project addresses:

CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ER's for initial contact
CN.3- Poor insurance support or uninsured

CN.4- High incidence of obesity, diabetes mellitus and heart disease

CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new project for PMH. We have a population who is in dyer need of being educated in regards to healthcare, available community resources, specialty care after initial physician contact, etc. It is important for PMH to provide a bridge of communication among patients, family members, survivors and healthcare providers. The CHW will assist in coordination of care among providers, arrange financial support and assist with paperwork. The CHW will need to address issues such as transportation and child care to allow for medical care. The CHW will also facilitate follow up appointments after ED visits and with specialty care when needed.

Related Category 3 Outcome Measure: OD-9 Right Care, Right Setting
IT.9.2 ED appropriate utilization *(Standalone measure)*

- Reduce all ED visits
- Reduce Emergency Department visits for target conditions
- Congestive Heart Failure
- Diabetes
- End Stage Renal Disease
- Cardiovascular Disease /Hypertension, Behavioral Health/Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Asthma

Reasons/rationale for selecting the outcome measures:
PMH selected OD-9.2.IT-9.2 due to the misuse of the ED by patients who desire to use the ED as a place to receive primary care. Patients misuse the ED department because of many factors in our community, for example lack of funds, lack of insurance, language barriers, and lack of education on the entire ED process versus a clinic setting, just to name a few. As our Community Needs Assessment reflects Castro County has an abundant population that is very vulnerable because of ethnic, cultural, economic, geographic, and health characteristics. Our residents are in a group that is at risk for not obtaining the necessary medical care, and thus constitutes a potential threat to their health.

Relationship to other Projects: This Category 2 project relates to our Category 3 outcome 136142011.3.1, IT-9.2 ED Appropriate Utilization. We believe that having a patient navigation program will help us reduce inappropriate ED utilization.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation: Plains Memorial Hospital TPI 136142011 for Category 2

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5	The development of the patient care navigation program will assure patients receive high-quality and patient centered care in the most cost effective manner. The program will focus on the targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others.) This will improve outcomes as well as being a cost effective to both the patient and PMH.	**5**
Addresses Community Need(s)	The Community Needs Assessment shows an abundant population that is very vulnerable because of ethnic, cultural, economic, geographic, and health characteristics. Our residents are in a group that is at risk for not obtaining the necessary medical care, and thus constitutes a potential threat to their health. Castro County, like many other counties, faces many community needs and challenges. With our plan we hope to address many of those needs, such as transportation, communication, specialty care, child care, follow up appointments and medication. PMH believes facing these challenges will decrease the cost and help to provide the right care in the right setting. We struggle with the misuse of the ED for non-urgent, non-emergent care. We average 220 patients per month through the ED. Approximately 70% of these visits are for non-urgent, non-emergent care. They are using the ED to receive primary care services instead of accessing the rural health clinic.	**5**
Project Scope/Size	This is the only project we are proposing in Pass 1. PMH values Category 2 and 3, over the next 5 years, at $628,065. The project will encompass ED visits with our primary focus on those that misuse the ED. As the CHW conducts surveys, quality improvement initiatives and follows up with patients he/she will be able to educate, coordinate, and maximize healthcare needs for all patients that are associated with the hospital and the county. The CHW will have to familiarize him/herself with the ethnic, cultural, geographic, education, economic and healthcare characteristics specific to our county.	**5**
Project Investment	Our total project investment for Category 2 including IGT will be $516,033.	**5**

136142011.2.1	2.9.1	2.9.1.A-E	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care	
Plains Memorial Hospital			**136142011**	
Related Category 3 Outcome Measure(s):	**136142011.3.1**		**IT-9.2**	**ED Appropriate Utilization**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-2. Milestone: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. P-2.1. Metric: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. a. Workforce development plan for patient navigator recruitment, training and education. Baseline/Goal: Our baseline is 0 our goal is to hire one individual to be the Patient Navigator for the project. The hiring of this person will take careful consideration of education and background. Data Source: HR Process of hiring a qualified individual.	P-3. Milestone: Provide care management/navigation services to targeted patients. P-3.1. Metric: Increase in the number or percent of targeted patients enrolled in the program. Our baseline is 0 we want to enroll at least 10% or 184 of the targeted patients into the program. a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified c. Data Source: Enrollment reports d. Rationale/Evidence: Ineffective navigation of the health care system by patients may lead to poorer outcomes and inefficiencies because of delayed care, failure to receive proper care or treatments, or care being received in more expensive locations (i.e., emergency rooms). Baseline/Goal: We have -0- patients enrolled. Our goal is to enroll 10% or 184 of identified targeted patients (frequent non urgent, non emergent		I-8. Milestone: Reduction in ED use by identified ED frequent users receiving navigation services. I-8.1. Metric: ED visits pre- and post-navigation services by individuals identified as ED frequent users. a. Difference in total number of ED visits pre- and post-navigation services. Data Source: Claims and EHR/registry, and ED logs. Goal: Our Goal is to reduce the ED utilization of the patient's enrolled in the navigation program by 5% or 9 patients. This will be measured by the difference in total number of ED visits pre- and post-navigation Services. Estimated Milestone 4 Incentive Payment: $69,726 P-3. Milestone: Provide care management/navigation services to targeted patients.	I-8. Milestone: Reduction in ED use by identified ED frequent users receiving navigation services. I-8.1. Metric: ED visits pre- and post-navigation services by individuals identified as ED frequent users. a. Difference in total number of ED visits pre- and post-navigation services. Data Source: Claims and EHR/registry, and ED logs. Goal: Our Goal is to reduce the ED utilization of the patient's enrolled in the navigation program by an additional 5% for a total of 10% or 28 patients. This will be measured by the difference in total number of ED visits pre- and post-navigation Services. Estimated Milestone 5 Incentive Payment: $119,479

136142011.2.1	2.9.1	2.9.1.A-E	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care	
Plains Memorial Hospital			**136142011**	
Related Category 3 Outcome Measure(s):	**136142011.3.1**		**IT-9.2**	**ED Appropriate Utilization**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Estimated Milestone 2 Incentive Payment: $119,077	ED users) into the program. Data Source: ED logs, EHR, Patient Navigation program materials and database Estimated Milestone 2 Incentive Payment: $138,025		P-3.1. Metric: Increase in the number or percent of targeted patients enrolled in the program by 5% for a total of 15% or 277 patients. a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified c. Data Source: Enrollment reports Baseline/Goal: Our goal is to increase enrollment from 184 or 10% to 277 or 15% of identified targeted patients (frequent, non urgent ED) into the program. Estimated Milestone 4 Incentive Payment: $69,726	
DY 2 Estimated Milestone Bundle Amount: $119,007	DY 3 Estimated Milestone Bundle Amount: $138,025		DY4 Estimated Milestone Bundle Amount: $139,452	DY5 Estimated Milestone Bundle Amount: $119,479
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $515,963				

Project Option: 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
Performing Provider Name/TPI: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital/126840107
Unique Project ID: 126840107.2.1
PROJECT Components: 2.2.1.A-E

Provider: Preferred Hospital Leasing, Inc dba Collingsworth General Hospital (CGH) is a 13-bed Critical Access hospital located in Collingsworth County, Texas. CGH is the only hospital in the county and serves a population of 3,092 scattered over 918.44 square miles.

Interventions: The project will implement a Care Management Team to ensure proper access to care, appointment scheduling, and to reach patients early in the disease process and when they are at risk of leaving the care of Collingsworth General Hospital. Once recruited, patients will receive follow-up phone calls, communication, education and support from team members to ensure that patients continue treatment, medication management, and follow-ups.

Need for the Project: Over the past 10 years, the number one admitting diagnosis to CGH is Congestive Heart Failure and other chronic diseases. Historically, patients with chronic disease are seen in the general clinic population and are monitored by our physicians. No special team focus or outside resources have been utilized to manage the disease process or to emphasize a change in lifestyle. Wellness measures are not the focus of our treatment plans and prevention measures are secondary to treatment.

Target Population: Our target population is the patients in our service area with chronic disease or who are pre-disposed to a chronic disease. 36% of adults aged 18-64 are without insurance according to the 2010 County Health Rankings. (http://www.countyhealthrankings.org) Our RHC sees an average of 575 patients a month. Of these patients, approximately 55 are uninsured (10%) and 100 are Medicaid (17%).

Patient Benefits: Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. By DY3, 8 staff (including providers) will be trained in Chronic Care Management model.

Category 3 outcome measures: From 2005-2010, 369 adult residents of Collingsworth County were hospitalized with a chronic disease. According to County Health Rankings, 156 hospitalizations were preventable. Our goal is to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. . IT-1.10 Diabetes Care: HbA1c poor control (>9.0 %) was chosen based on data from our clinic EHR. Patients with a diagnosis of Diabetes Type 1 or Diabetes Type 2 will see their HbA1c >9 be reduced.

Project Option: 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
Performing Provider Name/TPI: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital/126840107
Unique Project ID: 126840107.2.1
PROJECT Components: 2.2.1.A-E

Project Description:
Collingsworth General Hospital proposes to expand Chronic Care Management Models.

The project would improve effective management of chronic conditions and ultimately improve patient clinical indicators, health outcomes and quality as well as reduce unnecessary acute and emergency care utilization. The Chronic Care Management Program will provide for a collaborative, multi-disciplinary team that may include but not be limited to Providers, Licensed Nurses, Dietician, Physical Therapist (PT) and other Rehab personnel as needed, Certified Health Coach (HC), Case Manager (CM), Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers.

Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on an assessment of patients' risk of developing complications, comorbidities or utilizing acute or emergency services. These chronic health conditions may include diabetes, congestive heart failure, chronic obstructive pulmonary disease, among others, all of which are prone to co-occurring health conditions and risks.

Chronic Care Management models are needed in rural areas - specifically models which take a community-wide problem-solving focus. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million.[29] There are 62 million Americans currently residing in rural areas. It is estimated that 20 percent of the rural population is uninsured and this number is projected to increase to 25 percent by 2019. The need for increased access to care and insurance coverage is especially crucial for rural populations because they receive less preventive care and have higher rates of all chronic diseases than their urban counterparts (Bailey, 2010). 2009 Health Currents Report lists Collingsworth County with a population of 3,033 with 26.60 percent of the population being Hispanic. In 2008, there were 43 deaths in Collingsworth County. Of those 43 deaths, 16 or (37 percent) were attributed to cardiovascular disease. 16 percent of the deaths were due to cancer.

The CCM team will ensure proper access to care, appointment scheduling, and will use targeted outreach strategies and health education to reach patients early in the disease process and when they are at risk of leaving the care of Collingsworth General

[29] http://www.hhsc.state.tx.us/1115-docs.pdf

Hospital. Once recruited, patients will receive follow-up phone calls, communication, education, and support from team members to ensure that patients continue treatment, medication management, and follow-ups.

Target zip codes: 79077, 79095, 79230 and 79251. We propose to target zip codes in Collingsworth County with the poorest chronic outcomes.

Goals and Relationship to Regional Goals:

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on a an assessment of patients' risk of developing complications, comorbidities or utilizing acute or emergency services.

Project Goals:

- Increase the number of patients participating in a chronic care management program.
- Decrease hospital admissions related to chronic disease
- Decrease unnecessary ED visits

This project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Chronic disease management initiatives use evidence-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. The program leverages the existing Collingsworth General Hospital infrastructure to meet the need for enrollment in the Chronic Care Management Program with the goal of improving the poor outcomes currently exhibited in Collingsworth County.

Challenges:

The primary challenge for this project will be to engage and build trust with patients. Creating and implementing a Chronic Care Management Model is a new initiative for Collingsworth County. Historically, patients with chronic disease are seen in the general clinic population and are monitored by our physicians. No special team focus or outside resources have been utilized to manage the disease process or to emphasize a change in lifestyle. Wellness measures are not the focus of our treatment plans and prevention measures are secondary to treatment. Introducing a new concept and style of disease management, cultural competency training

and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement and ensure program success.

5-Year Expected Outcome for Provider and Patients:

The implementation of a Chronic Care Management Model will lead to the reduction in reactive rescue care including ED and inpatient care and improve disease specific metrics. Introducing a new concept and style of disease management, cultural competency training and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement and ensure program success.

Starting Point/Baseline:

Currently, a patient chronic disease management program does not exist for patients at Collingsworth General. The baseline number of participants as well as the number of participating providers begins as 0 in DY2.

Rationale:

Promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings. There are many definitions of "chronic condition", some more expansive than others. We characterize it as any condition that requires ongoing adjustments by the affected person and interactions with the health care system. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive- responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible. To speed the transition, Improving Chronic Illness Care created the CCM, which summarizes the basic elements for improving care in health systems at the community, organizational, practice and patient levels. Evidence on the effectiveness of the CCM has recently been summarized.

Establish a healthcare program and provide support to the targeted population who are most at risk thus supporting the goals of RHP 12. There are 62 million Americans currently residing in rural areas. It is estimated that 20 percent of the rural population is uninsured and this number is projected to increase to 25 percent by 2019. 2009 Health Currents Report lists Collingsworth County

with a population of 3,033 with 26.60 percent of the population being Hispanic. In 2008, there were 43 deaths in Collingsworth County. Of those 43 deaths, 16 or (37 percent) were attributed to cardiovascular disease. Our facility will establish training for providers and a multi-disciplinary team will assist in diminishing the deficiencies in the current delivery system. Encourage providers to follow established best practice guidelines, coordinating care and offering follow-up to ensure positive outcomes, and building patients who are better informed and able to assist the providers in managing their chronic diseases.

Project Components:

Through the Expand Chronic Care Management Models, we propose to meet all required project components.

A) *Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system*- This will be accomplished by providing training to a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project. These providers can navigate the patient through the health care system, education process and build patients who are better informed and able to assist the providers in managing their chronic diseases.

B) *Ensure that patients can access their care teams in person or by phone or email*- Patients that are enrolled in chronic care management will be given access to contact their health care team. This contact will be in the form of phone numbers and email.

C) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources- Implementing this project will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. The multi-disciplinary team will initiate patient education as well as group and self-management support while utilizing available community resources.

D) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions*- Community and individual education, health and lifestyle coaches and other healthcare team members can assist in chronic disease management and encouraging compliance with treatment and preventative plans.

E) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations*- To achieve this component we will review chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions

between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care.

Unique community need identification numbers the project addresses:

- CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.2- Lack of mental health services, inability to gen an appointment, lack of insurance, need to use ERs for initial contact
- CN.3- Poor insurance support or uninsured
- CN.4- High incidence of obesity, diabetes mellitus and heart disease
- CN.10- High prevalence of asthma and care issues

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently, a Chronic Care Management program does not exist for patients at Collingsworth General Hospital. Our system offers case management services, but this is typically only accessible to admitted patients. The initiative will improve access for targeted patients while helping the system reach capacity for treating patients with chronic diseases.

Related Category 3 Outcome Measures:

OD-1 Primary Care and Chronic Disease Management:

IT-1.10 Diabetes Care: HbA1c poor control (>9.0 %)

Patients with a diagnosis of Diabetes Type 1 or Diabetes Type 2 will see their HbA1c >9 be reduced.

Reasons/rationale for selecting the outcome measures: Chronic disease management outcome data related to selected Category 3 outcomes are described above and are all identified as Rural Healthy People 2020 objectives and ARHQ quality indicators by the federal government. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care.

Relationship to other Projects: This project's focus on cultural competency and disease management for patients with chronic diseases ties to our RHP goals by assisting in transforming health care delivery from an episodic disease focused model of care to a patient-centered, coordinated care management delivery system that improves patient outcomes and satisfaction, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. Related Category 4 measures include potentially preventable admissions measures and readmissions in RD-1 and Patient Satisfaction in RD-4.1.

Relationship to Other Performing Providers' Projects in the RHP: Parmer Medical Center in Friona, Texas is another facility in RHP 12 that is designing and developing a Chronic Care Management Model for their population.

Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their

projects. In addition to face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. The chronic care management model (CCMM) addresses the healthcare needs of all patients regardless of their financial resources. By implementing the CCM Model, we should be able to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population.	**5**
Addresses Community Need(s)	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. RHP 12 has identified Expanding Chronic Care Management as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN3- Poor insurance support or uninsured. CN4- High incidence of obesity, diabetes mellitus and heart disease CN10- High prevalence of asthma and care issues RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.3 and CN.4 have been defined as *Urgent Needs*, and CN.10 falls in the category of *Important Need But Less Urgent.* The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.	**5**
Project Scope/Size	From 2005 - 2010, 369 adult residents of Collingsworth County were hospitalized with a chronic disease resulting in Collingsworth County receiving $3,631,688 in charges for those hospitalizations that were potentially preventable if the residents had increased access to care, had cooperated with appropriate healthcare, and had a multi-disciplinary support team to assist in monitoring and managing the chronic disease. We would implement a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project. Our RHC sees an average of 575 patients a month. Of these patients, approximately 55 are uninsured (10%) and 100 are Medicaid (17%).	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Chronic Care Model, so our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all members of our multi-disciplinary staff and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**4**

126840107.2.1	**2.2.1**	**2.2.1.A-E**	**Expand Chronic Care Management Models**	
Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital			**126840107**	
Related Category 3 Outcome Measure(s):	**126840107.3.1**	**IT- 1.10**	**Diabetes care: HbA1c poor control (.9.0%)**	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [P-3] Project Planning Develop a comprehensive care management **Metric 1:** [P-3.1] Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. **Baseline/Goal:** Develop program **Data Source**: Program materials Estimated Milestone 1 Incentive Payment: $34,164	**Milestone 2:** [P-2] Project Planning Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care. **Metric 1:** [P-2.1] Increase percent of staff trained **Baseline/Goal:** staff trained will be 8 (including providers) **Data Source:** HR, Training Program materials Estimated Milestone 2 Incentive Payment: $37,271		**Milestone 3: [I**-17] Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally **Metric 1:** [I-17.1] 3 additional patients receive care under the Chronic Care Model for a chronic disease or for MCC **Goal: 3** patients receive care under the Chronic Care Model for a chronic disease or for MCC **Data Source:** EHR, Claims Estimated Milestone 3 Incentive Payment: $ 37,379	**Milestone 3: [I**-17] Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally **Metric 1:** [I-17.1] 5 additional patients receive care under the Chronic Care Model for a chronic disease or for MCC **Goal: 3** additional patients receive care under the Chronic Care Model for a chronic disease or for MCC **Data Source:** EHR, Claims Estimated Milestone 4 Incentive Payment: $ 30,878
DY 2 Estimated Milestone Bundle Amount: (Add incentive payment amounts from each milestone): $34,164	DY 3 Estimated Milestone Bundle Amount: (Add incentive payment amounts from each milestone): $ 37,271		DY4 Estimated Milestone Bundle Amount: (Add incentive payment amounts from each milestone): $ 37,379	*DY5 Estimated Milestone Bundle Amount: (Add incentive payment amounts from each milestone): $30,878*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): 139,692				

Project Option: 2.4.3 – Increased Patient Satisfaction
Performing Provider Name/TPI: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital/126840107
Unique Project ID: 126840107.2.3 – **"PASS 3b"**

Provider: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital (CGH) is a 13-bed Critical Access hospital located in Collingsworth County, Texas. CGH is the only hospital in the county and serves a population of 3,092 scattered over 918.44 square miles.
Interventions: The project will implement a system wide patient satisfaction survey process to measure the patient's perception of and satisfaction with their care experience in our facility. The experience may include proper access to care, appointment scheduling, and outreach to patients early in the disease process and when they are at risk of leaving the care of Collingsworth General Hospital.
Need for the Project: The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven upward partially by the increase of costly readmissions and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by comprehensive patient questionnaires detailing the patients' satisfaction or dissatisfaction with the hospital's services.

- **Target population:** Our target population is the patients or patient representatives in our service area who have been admitted, have utilized our Emergency Department, our clinic and/or outpatient services. From 2005-2010, 369 adult residents of Collingsworth County were hospitalized with a chronic disease. According to County Health Rankings, 156 hospitalizations were preventable. Our RHC sees an average of 575 patients a month. Of these patients, approximately 55 are uninsured (10%) and 100 Medicaid (17%).

Patient Benefits: A system wide patient satisfaction program will improve the knowledge base of providers as well as of patients as it relates to the effectiveness and overall success or inefficiencies of our health care system, will assist us in identifying areas to improve care and coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to be involved in having a voice in the environment in which they receive health care. Of the 575 patients, approximately 58 or 10% are going to receive the survey in DY4 and 116 or 20% in DY5.
Category 3 outcomes measures: When we provide a supportive environment and patients are satisfied with the care that they have received from our doctors, nurses and other health care team then the potential for compliance with the preventive or treatment plan is much more likely. We will measure our effectiveness based on scores from our internal Patient Satisfaction surveys. Surveys will include questions relating to care received from physicians and nurses, the hospital environment and the discharge experience. By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. The patient experience and satisfaction model addresses the healthcare

needs of all patients regardless of language, ethnicity or cultural beliefs. By implementing the Patient Experience Model, we should be able to improve patient satisfaction and promote a healthier population. From 2005-2010, 369 adult residents of Collingsworth County were hospitalized with a chronic disease. According to County Health Rankings, 156 hospitalizations were preventable. Annually this represents 31 patients and our goal is to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. Admissions will be reduced by 10 % in DY4 and DY5.

Project Option: 2.4.3 – Increased Patient Satisfaction
Performing Provider Name/TPI: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital/126840107
Unique Project ID: 126840107.2.3 – **"PASS 3"**

Project Description: ***Collingsworth General Hospital plans to enhance and expand its patient satisfaction Program.***

As a small hospital many services are referred to larger urban providers with the capability to provide a more robust patient experience. At CGH, we are unable to provide patient survey and implement patient experience training due to cost constrains. However, we see this as a valuable tool to progress transformation in our system of care delivery. By implementing and expanding satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care and meet this challenge. By doing so the hospital's goal is to better understand the needs of its unique patient base in order to better care for and provide higher quality of care to those patients. Additionally, a system wide patient satisfaction program will be implemented from the top down emphasizing its importance including new employee orientation, public reporting of the hospital scores, individual recognition of documented employee satisfaction efforts, and the implementation of needed upgrades based on patient comments. We believe that patient engagement and patient experience is transformational. The surveys utilized will measure and account for education patients about his or her treatment options, how to achieve better health outcomes and how to be more engaged and responsible for their own healthcare.

Target zip codes: 79077, 79095, 79230 and 79251

Goals and Relationship to Regional Goals: The goal of this project is to develop and implement a plan to improve the patients' experience of care as an institutional priority. This will be accomplished by implementing new tools to measure the patients' experience and satisfaction. Additionally, the goal is to improve the patient experience by strengthening the communication skills of our employees. So engaging employees' commitment and creativity in the overall patient experience project is a critical early step.

Project Goals:

Improve how the patient experiences the care and the patient's satisfaction with the care provided. The state healthcare transformation is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience. This will require a redesign of primary care to meet the needs of patients for timely, patient-centered, continuous, and coordinated care to enhance access to care regardless of type of insurance. The overall approach to redesigning the patient experience will be

centered on cultural change at the organizational level. This will involve the practitioners and staff in the clinic and in-patient setting as well as the patients and their families or caregivers. An organizational strategy will be developed so that entities will manage patient experience and create avenues to implement the strategic plan/vision. Providers' performance will be measured, among other factors, by the extent to which patient experience improves systematically.

Patient experience will be assessed through focused surveys. The architecture for patient focused surveys should be modeled after the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool, which includes the following domains: patients are getting timely care, appointments, and information; how well providers communicate with patients; patients' rating of provider; and assessment office staff. The Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) survey can be used to assess patient experience in the hospital setting. Certain supplemental modules for the adult survey CG-CAHPS may be used to establish additional outcomes: Health Literacy, Cultural Competence, Health Information Technology, and Patient Centered Medical Home.
These surveys will be mandatory, and will be administered at the end of the medical episode, six weeks after the visit (to avoid recall bias) and six months if no other episode of care intervened.

This project meets the following regional goals:

- Transform health care delivery through a coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:

Trust is the basis for establishing a strong patient-provider alliance that is the foundation for improved health outcomes, and good communication is the key to trust. The challenge at CGH is to standardize principles of communication for all patients regardless of language, ethnicity or cultural beliefs, while simultaneously finding a way to personalize the message based on the needs of each patient, and to ensure that all staff is skilled communicators. Another key challenge will be in ensuring customer participation in the survey and subsequent quality initiative and process.

5-Year Expected Outcome for Provider and Patients:

Primarily this project will be to engage and build trust with patients. Creating and implementing a plan that will standardize principle communication for all patients. Improving patient experience and satisfaction is a new initiative for CGH. Historically, there has not been a plan or project in place that inhabits all staff to focus on patient experience and satisfaction. Introducing this new concept of a standardized patient experience model will involve extensive training for all staff to facilitate patient engagement and ensure program success.

- Ensure that reports on the patient experience are available monthly, disseminated throughout the organization, and results are discussed and included in the process of improvement.
- Train and evaluate staff in communication skills competencies.
- Improve score on HCAHPS patient experience survey by TBD% over the 2013 baseline. (TBD after initial surveys are in and baseline established)
- Include the Spanish speaking and less educated population

Starting Point/Baseline:

Currently, CGH does not have a system wide patient satisfaction survey in place. Therefore we will be creating and implementing this program to include both inpatient and outpatient.

Rationale:

Over time, implemented projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care. At CGH, we are unable to provide patient survey and implement patient experience training due to cost constrains. However, we see this as a valuable tool to progress transformation in our system of care delivery. By implementing and expanding satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care and meet this challenge. By doing so the hospital's goal is to better understand the needs of its unique patient base in order to better care for and provide higher quality of care to those patients. When we provide a supportive environment and patients are satisfied with the care that they have received from our doctors, nurses and other health care team then the potential for compliance with the preventive or treatment plan is much more likely.

Metrics and Milestones: Establishing a healthcare program to provide support and satisfaction to our population will enhance the goals of RHP 12. Providing training for all staff will assist in diminishing the deficiencies in the current delivery system encouraging providers, nursing and ancillary staff to provide the best patient experience possible from our facility.

DY2- We will appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance. Provide documentation of an executive assigned responsibility experience performance. DY3- Write and disseminate a patient/family experience strategic plan. Submit a strategic plan and documentation of the dissemination of that plan throughout the organization. DY4- Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data. Develop a new patient experience survey tool or revise and improve the current ones along with documentation of inquiry materials. DY5- Increase the number of patient satisfaction surveys distributed and collected. Increase the number of HCAHPS surveys distributed and collected.

Project Component: Implement and innovative an evidence based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in Category 3, Outcome Domain – 6 Patient Satisfaction.

Unique community need identification numbers the project addresses:

- CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact
- CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult.
- CN.6- Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

Currently our ability to improve is impaired by inadequate tools and data. Collingsworth General Hospital's commitment to improving the patient's experience of care is embedded in its overall strategic plan. Some areas of our facility use homegrown survey tools that make it difficult to compare and improve performance. 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 patient's experience and satisfaction. In addition, internal display and sharing of data will give staff the tools and information necessary to improve the experience.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measures: The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven upward partially by the increase of costly readmission and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by detailed patient questionnaires detailing the patients' satisfaction or dissatisfaction of the hospital's services.

Relationship to other Projects:

This project's focus on patient experience ties to our RHP goals by assisting in transforming health care to a patient centered, coordinated care management delivery system that improves patient outcomes and satisfaction, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. We have proposed Category 2 project is 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases and 2.4.3 Increase patient satisfaction. We feel that if we have a Patient Satisfaction Program in place this will enhance the quality of the Chronic Care Management Model project. Related Category 3 outcome measures are IT-6.1 Percent improvement over baseline of patient satisfaction scores. Related Category 4 measures include potentially preventable readmissions in RD-1 and Patient Satisfaction in RD-4-1.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face to face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Redesign to Improve Patient Experience will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will ensure positive outcomes and will enhance patients' abilities to manage their own illnesses. The patient experience and satisfaction model addresses the healthcare needs of all patients regardless of language, ethnicity or cultural beliefs. By implementing the Patient Experience Model, we should be able to improve patient satisfaction and promote a healthier population. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.	**5**
Addresses Community Need(s)	RHP 12 has identified Redesign to Improve Patient Experience as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: • CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care • CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. • CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult. • CN.6- Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.5 and CN.6 have been defined as *Urgent Needs.*	**4**
Project Scope/Size	We would implement a nationally recognized survey that would capture pertinent data using a patient questionnaire detailing the patients' satisfaction or dissatisfaction of the clinic and/or hospital's services. Once obtaining this data, the facility will conduct quality improvement for the project using methods of a rapid cycle improvement process. Activities may include, but will not be limited to, identifying project impacts, "lessons learned", and opportunities to scale all or part of the project to a broader patient population. Our RHC sees an average of 575 patients a month. Of these patients, approximately 55 are uninsured (10%) 100 are Medicaid (17%).	**5**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a system wide patient experience model, so our investment in a nationally recognized survey, development of program, educating key executive staff and training for all staff members will be costly. Additional equipment purchases and maintenance will be determined after establishing our project baseline data. This project is not funded through a collaboration option.	**5**

126840107.2.3 – **"PASS 3"**	**2.4.3**	**N/A**	**Increase Patient Satisfaction**	
Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital			**126840107**	
Redesign to Improve Patient Experience	**126840107.3.3**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*		*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: P-1 Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance P-1.1 Metric: Documentation of an executive assigned responsibility experience performance Baseline/Goal: develop program and establish baseline Data Source: Organizational Chart or job description (if percentage of time) *Estimated Milestone 1 Incentive Payment:* *$ 53,306*	*Milestone 2:* P-2 Write and disseminate a patient/family experience strategic plan P-2.1: Metric: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization Baseline/Goal: Currently we have no plan. We will establish a written plan and educate entire organization Data Source: Internal organizational communication, experience strategic plan *Estimated Milestone 2 Incentive Payment:* *$55,670*		*Milestone 3* P-8 Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data. Metric: P-8.1 Develop a new patient experience survey tool or revise and improve the current ones. P-8.1 a. Documentation of inquiry materials. Baseline/Goal: Show increase clinic patient participation by 58 or (10%). Baseline is 0% Data Source: Documentation of inquiry materials *Estimated Milestone 4 Incentive Payment:* *$ 53,132*	*Milestone 4:* I-X Increase the number of patient satisfaction surveys distributed and collected. Metric I-X.1 Increase the number of HCAHPS surveys distributed and collected Baseline/Goal: Increase patient participation to 116 (20%) Data Source: HCAHPS surveys *Estimated Milestone 5 Incentive Payment:* *$ 42,199*
DY 2 Estimated Milestone Bundle Amount: $53,306	*DY 3 Estimated Milestone Bundle Amount: $ 55,670*		*DY4 Estimated Milestone Bundle Amount: $ 53,132*	*DY5 Estimated Milestone Bundle Amount: $42,199*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $204,307				

Project Option: 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Performing Provider: Sunrise Canyon Hospital / 136492909
Project ID: 136492909.2.1 – **"PASS 2"**
Project Components: 2.13.1.a-e

PROVIDER: Sunrise Canyon Hospital (SRCH) is a 30-bed inpatient psychiatric hospital, owned by StarCare Specialty Health System (StarCare) a community center/governmental entity/ public provider under Chapter 534 of the Texas Health and Safety Code, serving over 5,000 people per year with an annual budget in excess of $30,000,000 per year.

INTERVENTIONS: During Pass 2, SRCH will open a new integrated primary and behavioral health clinic. Many people discharged from SRCH do not meet eligibility for ongoing outpatient services; neither do many people released from the criminal justice system. This project will allow those people as well as others to have access to urgently needed psychiatric care and medications, as well as access to routine physical medical care.

NEED FOR THE PROJECT: SRCH selected this project because it directly addresses the Region 12 Community Needs Assessment ID#s *CN1 (Critical Need) Severe primary care provider shortage, wait time, expense, lack of insurance, access to care; CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact; and CN3 (Urgent Need) Poor insurance support or uninsured.* In addition, because it assists with access to care, this project indirectly addresses all of the other identified Community Needs.

TARGET POPULATION: SRCH's new integrated primary and behavioral health care clinic will serve people discharged from the Psychiatric Emergency Services Center (PESC – StarCare's Pass 1 Project) as well as people in the general public, including people who are homeless, people recently released from jail, veterans, etc. SRCH estimates it will provide at least 600 office visits annually during DY4 and DY5 and expects to serve at least 225 people annually in DY4 and DY5, 95% of whom are expected to be Medicaid eligible or indigent.

CATEGORY 2 EXPECTED PATIENT BENEFITS: During each year, DY4 and DY5, SRCH estimates it will provide at least 600 office visits. SRCH estimates a total of 450 people (225/year) could be impacted by this project, with a 5% decrease from baseline in preventable admissions or readmissions into Criminal Justice System in DY4 and a 10% decrease from baseline in DY5.

CATEGORY 3 OUTCOMES: (IT – 9.2) Emergency department appropriate utilization: This project is expected to reduce psychiatric-related emergency department visits from the baseline established in DY3, by 10% in DY4 and 15% in DY5.

Project Option: 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Performing Provider / TPI: Sunrise Canyon Hospital / 136492909
Project Identification Number: 136492909.2.1 – **"PASS 2"**
Project Components: 2.13.1.a-e

Project Description: One in four , approximately 57.7 million Americans, experiences a mental health issue every year.[30] For the average family, nothing is more confusing or devastating than trying to help a loved one struggling with a mental illness. In Lubbock, as throughout the rest of the country, the focus in healthcare is on decreasing cost and improving outcomes. This project proposes a methodology to accomplish both of these goals, reduction of cost through diversion of people whose primary need is access to health care from emergency departments, inpatient settings and jail, into a more effective and efficient delivery system of care.

During Pass 2, Sunrise Canyon Hospital (SRCH) will implement a project opening a new integrated primary and behavioral health clinic. Many people discharged from SRCH do not meet eligibility for ongoing outpatient services; neither do many people released from the criminal justice system. This project will allow those people as well as others to have access to urgently needed psychiatric care and medications, as well as access to routine physical medical care. [Note: SRCH is owned by StarCare Specialty Health System, but is eligible to submit an independent project during Pass 2. The new integrated clinic described herein is totally separate from StarCare Specialty Health System's integrated health care clinic. Each clinic will serve a different population of people.] SRCH's new integrated primary and behavioral health care clinic will serve adolescents and adults discharged from the Psychiatric Emergency Services Center (PESC – StarCare Specialty Health System's Pass 1 Project) as well as people in the general public, including people who are homeless, people recently released from jail, veterans, etc. SRCH estimates it will provide at least 600 office visits annually during DY4 and DY5 and expects to serve at least 225 people annually in DY4 and DY5, 95% of whom are expected to be Medicaid eligible or indigent. SRCH's new integrated primary and behavioral health clinic will be housed inside the PESC facility so as to promote continuity of care and ease of access.

SRCH will provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical issues. These populations often have multiple concomitant issues such as substance abuse, traumatic injuries, homelessness, cognitive challenges and lack of daily living skills and lack of natural supports. The State's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and

[30] *NIMH: The numbers count—Mental Disorders in America,* National Institute of Health, available at www.nimh.nih.gov/publicat/numbers.cfm

functional limitations, but can serve only a fraction of the medically indigent population. It does not serve other high risk behavioral health populations and does not provide the range of services needed to deal with complex psychiatric and physical needs. These complex populations become frequent users of local public health systems.

Goal of Project: The primary goal of this project is to ensure people receive coordinated, timely and site-appropriate behavioral and physical health services. Specifically, SRCH will assist with averting outcomes such as potentially avoidable inpatient admission and readmissions in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community.

Relationship to Regional Goals: Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The resulting document ranked the needs in tiers, according to the availability of evidence documenting each need. Tier one included the two (2) most pressing needs in RHP 12: 1) a severe lack of primary care access including provider shortages, financial barriers, wait times, and length of time to get an appointment; and 2) a lack of mental health services including lack of available appointments, insurance coverage, and emergency room usage for mental health issues. Tier two identified other priority issues as: 1) uninsured and underinsured; 2) high incidence of obesity, diabetes, and heart disease; 3) need for specialty care; and 4) need for cancer screenings; and 5) insufficient maternal and prenatal care. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement.

SRCH's new integrated primary and behavioral health care clinic directly relates to the Region 12 goals of increased access to care and increased prevention and early detection activities. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.

Challenges: The primary challenge associated with this project is a limited availability of qualified practitioners to provide needed health care services.

5-Year Expected Outcome for Performing Provider and Patients:

- Performing Provider Perspective – improved health care infrastructure that better serves the Medicaid-funded and uninsured residents of our counties; coordinated care delivery system; improved efficiency and cost growth containment.
- Patient Perspective – high quality, patient-centered care; improved access to coordinated health care; improved health outcomes

Starting Point/Baseline: Operating an integrated primary and behavioral health care clinic represents a new initiative for SRCH; therefore, the starting point/baseline for the number of people to be assisted is zero.

Reason/Rationale for Selecting Measure:
Access to needed health care is paramount to achieving all desired patient and system outcomes in the Texas Healthcare Transformation and Quality Improvement Program. According to the Agency for Healthcare Research and Quality, the University of New Mexico studied how *low-income, vulnerable populations often fail to obtain needed healthcare and social services via conventional avenues and are at high risk of untreated health problems that may require expensive inpatient and emergency department (ED) care.*[31] Comorbidity of diagnoses is common and greatly increases the cost to the healthcare service delivery system. According to the United States Department of Health and Human Services, *healthcare use/costs are twice as high in diabetes and heart disease patients with* [who also have] *depression.* Consider the following:[32]

Physical Condition	Annual Cost: Patients WITHOUT a Mental Health Diagnosis	Annual Cost: Patients WITH a Mental Health Diagnosis
Heart Disease	$4,697	$6,919
High Blood Pressure	$3,481	$5,492
Asthma	$2,908	$4,028
Diabetes	$4,172	$5,559

Inadequate outpatient services for people with mental illness, who don't qualify for Department of State Health Services (DSHS) funded care, have long been an identified gap in the Lubbock continuum of health care. Currently, people who fall outside of the DSHS "target population" have limited options available for care: emergency rooms, inpatient hospitals and jails. While emergency room treatment is necessary for serious physical/medical needs, inpatient hospitalization is necessary to ensure individual safety and incarceration is necessary for some classes of crimes, expanded outpatient psychiatric services will offer a more cost-effective

[31] http://www.innovations.ahrq.gov/content.aspx?id=2933
[32] Original source data 2002/2003 MEPS, as cited by Croghan, et al: *Why Should MH Problems Be Priorities for the Patient Centered Medical Home?*

and clinically appropriate alternative in many circumstances. Patients with mental illness overuse emergency rooms when appropriate mental health care is not available. In one study, 25-30% of people presenting to emergency rooms were really there because of non-emergent mental health issues, resulting in unnecessary cost.[33] In Texas, State Mental Health Facilities are considerably more expensive than community-based services, costing an average of $401 per day. The average length of stay in the State Mental Health Facility System is 29 days and the cost of an average stay is $11,629. Incarcerating a person who has a serious mental illness can cost taxpayers around 3 times as much as jailing other inmates without mental illness. The average daily cost for an inmate with severe mental illness is $137. The average length of stay in jail for a person with mental illness is 80 days. The total average cost for an inmate with mental illness costs $10,960. In addition to higher costs, inmates with mental illness also tend to stay in jail longer than the general inmate population. Without access to critical community-based mental health services like integrated health care and medications, people with serious mental illness cannot manage their illness and are more likely end up in higher cost services.[34]

Core Project Components:

a) SRCH will assess size, characteristics and needs of the populations to be served (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays.) Factors will include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement. SRCH will engage emergency departments and other human service entities in its service delivery area to develop a mechanism by which people can be referred to the Integrated Primary and Behavioral Health Care Clinic.
b) SRCH will review literature/experience with populations similar to target population to determine how best to operate the Integrated Primary and Behavioral Health Care Clinic such that negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters are averted, while promoting correspondingly positive health and social outcomes/quality of life.
c) SRCH will develop a project evaluation plan using qualitative and quantitative metrics to determine outcomes.
d) SRCH will design its model to include an appropriate range of community-based services, primarily access to physical and behavioral health care and medications.
e) SRCH will conduct Continuous Quality Improvement (CQI) activities using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. SRCH will assess the impact of the Integrated

[33] http://link.springer.com/article/10.1007%2Fs10597-012-9523-0?LI=true
[34] http://www.ttbh.org/Documents/BudgetCutsCommunity.pdf

Primary and Behavioral Health Care Clinic, based on standardized quantitative measures and qualitative analysis relevant to the target population.

Unique Community Need ID#: CN1 (Critical Need) Severe primary care provider shortage, wait time, expense, lack of insurance, access to care; CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact; and CN3 (Urgent Need) Poor insurance support or uninsured. In addition, because it assists with access to care, this project indirectly addresses all of the other identified Community Needs.

Milestones & Metrics: The milestones (2.13.1 P-1, P-2, P-3, P-7 and I-1) and metrics (2.13.1 P-1.1, P-2.1, P-3.1, P-7.1 and I-1.1) were selected because of their applicability to CN1, CN2 and CN3, outlined in the Region 12 Community Needs Assessment.

Related Category 3 Outcome Measure(s): OD-9 Right Care, Right Setting; IT-9.2 ED appropriate utilization (standalone measure)/Emergency department visits for target conditions (Behavioral Health/Substance Abuse) SRCH expects to reduce Emergency Department visits from the baseline established in DY 3 (# of psychiatric-related ED visits that could have been made to the integrated clinic) by 10% in DY4 and 15% in DY5.

Reason/Rationale for Selecting Measure: According to the Region 12 Community Needs Assessment, an appropriate alternative to emergency departments is a "Critical Need."

Explanation of how focusing on the outcomes will help improve the health of low-income populations: Establishment of a new integrated primary and behavioral health care clinic will allow people access to specialized interventions and diagnosis-specific after care services and referrals. These offer more specialized psychiatric expertise than does a general emergency department. SRCH hopes to address the health care disparity of unequal access for people with low-income. Improved access to quality, timely healthcare impacts: overall physical, social and mental health status; prevention of disease and disability; quality of life; preventable death; and life expectancy.[35]

[35] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1

Relationship to Other Projects: SRCH does not have any other projects in the waiver. As stated earlier, SRCH is owned by StarCare Specialty Health System. All of StarCare's projects are related in that they focus on the same goals: increased access to needed healthcare in the most appropriate setting. StarCare's projects are:

- 084897001.1.1 – establishes a Psychiatric Emergency Service Center (PESC)
- 084897001.1.2 – adds an adolescent crisis respite component to the PESC

Relationship to Other Performing Providers' Projects in RHP & Plan for Learning Collaborative: Several performing providers in Region 12 are planning to add clinics; however, SRCH appears to be the only performing provider focused upon the target populations we have listed herein. Our RHP will encourage participation by all our partners in a Learning Collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure people receive coordinated, timely and site-appropriate healthcare services. SRCH hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	5
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. SRCH's integrated clinic directly relates to the Region 12 goals of CN1 (Critical Need) Severe primary care provider shortage, wait time, expense, lack of insurance, access to care; CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 (Urgent Need) Poor insurance support or uninsured.	5

Project Scope/Size Scale: 1 to 5 5 Greatest	During each year, DY4 and DY5, SRCH estimates it will provide at least 600 office visits. SRCH estimates a total of 450 people (225/year) could be impacted by this project, with a 5% decrease from baseline in preventable admissions or readmissions into Criminal Justice System in DY4 and a 10% decrease from baseline in DY5. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	4
Project Investment Scale: 1 to 5 5 Greatest	SRCH's investment in this project will be fairly significant. Staffing will include a Program Director, Psychiatrist, licensed nurses, an Administrative Assistant, etc. (shared with other, similar programs, for the purpose of economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc.	4

136492909.2.1	**2.13.1**	**2.13.1 a-e**	**Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**
Sunrise Canyon Hospital			**136492909**
Related Category 3 Outcome Measure(s):	**136492909.3.1**	**IT-9.2**	**ED Appropriate Utilization**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-1] Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. **Metric(s):** [P-1.1] Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical	**Milestone 2:** [P-2] Design community-based specialized interventions for target populations. **Metric(s):** [P-2.1] Project plans which are based on evidence/experience and which address the project goals. **Baseline/Goal:** Identify specialized intervention	**Milestone 4:** [P-3] Enroll and serve individuals with targeted complex needs. **Metric(s):** [P-3.1] Number of targeted individuals enrolled/served in the project. **Baseline/Goal:** At least 5% of the people discharged from the StarCare Psychiatric Emergency Service Center seen in the Integrated Health Care Clinic **Data Source:** Project documentation	**Milestone 7:** [P-7]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric(s):** [P-7.1] Participate in semi-annual meetings or seminars organized by the RHP.

utilization, ED utilization. **Baseline/Goal:** Identify population to be served **Data Source:** Project documentation; inpatient, discharge and ED records; state psychiatric facility records; survey of stakeholders; literature reviews **Milestone 1 Estimated Incentive Payment:** $1,755,759	(Prescription Medications) **Data Source:** Project documentation **Milestone 2 Estimated Incentive Payment:** $917,248 **Milestone 3:** [P-7] Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric(s):** [P-7.1] Participate in semi-annual meetings or seminars organized by the RHP. **Baseline/Goal:** Participate at least twice per year **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 3 Estimated**	**Milestone 4 Estimated Incentive Payment**: $583,339 **Milestone 5:** [P-7] Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric(s):** [P-7.1] Participate in semi-annual meetings or seminars organized by the RHP. **Baseline/Goal:** Participate at least twice per year **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 5 Estimated Incentive Payment:** $583,338 **Milestone 6:** [I-1]: Criminal Justice Admission/Readmissions **Metric(s):** [I-1.1] 5% decrease from baseline in preventable admissions or readmissions into Criminal Justice System **Baseline:** to be established in DY3 **Goal:** 5% decrease from baseline in preventable admissions or readmissions into Criminal Justice System	**Baseline/Goal:** Participate at least twice per year **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 7 Estimated Incentive Payment:** $694,949 **Milestone 8:** [I-1] Criminal Justice Admission/Readmissions **Metric(s):** [I-1.1] 10% decrease from baseline in preventable admissions or readmissions into Criminal Justice System **Baseline:** to be established in DY3 **Goal:** 10% decrease from baseline in preventable admissions or readmissions into Criminal Justice System **Data Source:** Claims/ encounters and clinical record data; anchor hospital and other hospitals, criminal justice

	Incentive Payment: $917,248	**Data Source:** Claims/ encounters and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records **Milestone 6 Estimated Incentive Payment:** $583,338	system records, local MH authority and state MH (CARE) data system records **Milestone 8 Estimated Incentive Payment:** $694,949
Year 2 Estimated Milestone Bundle Amount: $1,755,759	**Year 3 Estimated Milestone Bundle Amount:** $1,833,630	**Year 4 Estimated Milestone Bundle Amount:** $1,750,015	**Year 5 Estimated Milestone Bundle Amount:** $1,389,898
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,729,302			

Project Option:2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Performing Provider: Texas Panhandle Centers Behavioral and Developmental Health / 127378105
RHP Unique Identification Number: 127378105.2.1
Project Components: 2.13.1.a-e

- Provider: Texas Panhandle Centers Behavioral and Developmental Health is a local mental health authority providing behavioral and developmental health services in the northernmost 21 Texas counties, over 21,000 square miles with approximately 400,000 residents.
- Intervention(s): *A Continuum of Care Program* providing intensive wraparound services and supports for children and adults with behavioral health needs. Provides interventions and diversion from hospitals, jails, juvenile detention and other restrictive settings through enhanced care coordination, community outreach, social support, and culturally competent care. *The CoC Program will consist of: CHILD AND ADOLESCENT WRAPAROUND SERVICES*- an early service delivery model that provides individualized comprehensive services and supports to children/adolescents with serious emotional and/or behavioral disturbance; *30 DAY INTENSIVE OUTPATIENT TREATMENT*- Targeting adults who have a co-occurring diagnosis of substance abuse and mental illness and experience homelessness; and the *CRIMINAL JUSTICE DIVERSION UNIT*- created specifically to address current gaps in diversion services, this unit will target adults with behavioral health needs who have repeat contacts with the criminal justice system so they will not return, or not return as frequently.
- Need for the project: The Continuum of Care Program will address both Critical Needs identified in the RHP 12 Needs Assessment Summary- CN.1 (wait time, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as other community needs CN.8 (Alcohol abuse and binge drinking, substance abuse) and CN.9 (Tobacco use). As stated in the RHP 12 Needs assessment summary, only 41.7 of children ages 2 to 17 in Texas received the mental health care that they needed. There are currently no agencies in the Amarillo area that provide intensive outpatient substance abuse/behavioral health services targeting the Amarillo homeless population who are mentally ill and/or are substance abusers. And the prevalence of mental illness is three to four times higher among inmates in jail and prison than in the general population; almost half of inmates with mental illnesses are incarcerated for non-violent crimes.
- Target population: The target population is children and adults with behavioral health needs in the top 21 counties of the Texas Panhandle. Approximately 90% of these individuals will either be Medicaid eligible or indigent.
- Category 1 or 2 expected patient benefits: The project seeks to enroll 785 individuals in the CoC program in DY3, 850 individuals in the CoC program in DY4, an 915 individuals in the CoC program in DY5. Approximately 90% of our clients are either Medicaid eligible or indigent. 5% decrease in preventable admissions and readmissions into Criminal Justice System in DY4; 6% decrease in preventable admissions and readmissions into Criminal Justice System in DY5

- Category 3 outcomes: IT-10.1 Our goal is to demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD %

Project Option:2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Performing Provider: Texas Panhandle Centers Behavioral and Developmental Health / 127378105
RHP Unique Identification Number: 127378105.2.1
Project Components: 2.13.1.a-e

PROJECT DESCRIPTION:

CONTINUUM OF CARE PROGRAM: **Texas Panhandle Centers Behavioral and Developmental Health (TPC) proposes to implement *a Continuum of Care (CoC) Program* providing intensive wraparound services and supports for children and adults with behavioral health needs in the top 21 counties of the Texas Panhandle. The CoC Program will encourage services in the least restrictive setting that is clinically appropriate to meet the individual's needs and improve their quality of life, and will address children's behavioral health needs as well as adults.**

The CoC Program will consist of a three-pronged approach:

CHILD AND ADOLESCENT WRAPAROUND SERVICES- an early service delivery model that provides individualized comprehensive services and supports to children and adolescents with serious emotional and/or behavioral disturbance across the local service area. This program, which will initially be delivered through a partnership between TPC and Amarillo Independent School District targeting children in grades pre-k through 12th grade, is aimed at maintaining children in less restrictive school and family settings and preventing hospitalization, and will work with community agencies, families, and youths for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent service/supports for children and youth with a serious emotional disturbance and their families. Future focus will include expanding to surrounding school districts.

30 DAY INTENSIVE OUTPATIENT TREATMENT- Target adults who have a co-occurring diagnosis of substance abuse and mental illness who experience chronic or intermittent homelessness. Program will encourage services in the least restrictive setting that is clinically appropriate to meet the individual's needs. Services will include partnering with the City of Amarillo Department of Public Health, and with shelters to provide a sober living environment for program participants, behavioral health services, substance abuse services, crisis services, psychiatric services, case management, skills training, employment services, peer support and other services that promote overall health and wellbeing.

CRIMINAL JUSTICE DIVERSION UNIT- created specifically to address current gaps in diversion services, this unit will target adults with behavioral health needs who have repeat contacts with the criminal justice system so they will not return, or not return as frequently. Three pronged approach will include: *Crisis Transition* that will focus on pre-booking and post-booking diversion while headquartered at the Randall County Jail, and on treating repeat offenders reentering the local community as part of the Randall

County Prisoner Re-entry Program, a successful local diversion/reintegration program; *Court/Jail Liaison* that will advocate for clients with mental illness so that they can be treated in the least restrictive treatment environment that is feasible and will pursue incremental reductions in the number of law enforcement contacts, jail days, probation violations, or new charges for program participants; and *Service Coordination* that will provide increased engagement for clients who have been historically hard to engage and have ended up in a "revolving door" of encounters with law enforcement, mental health agencies, hospitals, etc.

Goals and Relationship to Regional Goals: The goal of this project is to **encourage services in the least restrictive setting that is clinically appropriate to meet the individual's needs**, **by creating a wide-reaching program that provides interventions and diversion from hospitals, jails, and other restrictive settings through enhanced care coordination, community outreach, social support, and culturally competent care to vulnerable and/or high-risk persons with behavioral health needs.** This COC Program addresses major cracks in the system that have previously resulted in children and adults with behavioral health needs not receiving needed treatment that could have kept their level of functioning from deteriorating and kept them out of criminal justice system, away from substance abuse, and out of the hospital.

This project meets the following regional goals:
The CoC Program will reach the RHP 12 Triple Aim Goals of assuring patients receive high-quality and patient-centered care in the most cost-effective ways. Intervening and treating a person before they are incarcerated or hospitalized is much more cost effective. The Continuum of Care Program will address both Critical Needs identified in the RHP 12 Needs Assessment Summary- Community Needs Identification: CN.1 (wait time, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as other community needs CN.8 (Alcohol abuse and binge drinking, substance abuse) and CN.9 (Tobacco use).

Challenges- The primary challenge for this project will be to engage and build trust with project clients. Targeted communities have historically been difficult to penetrate, but with proper provider training and effective procedures, the project will be successful. In particular, the involvement of clients and stakeholders in provision of services that can address the full spectrum of the participants' needs will facilitate client engagement.

Five Year Expected Outcome: Texas Panhandle Centers expects to see improvements in Quality of Life for persons enrolled in the program. Expected outcomes will relate to the project goals described above.
Starting Point/Baseline: A Continuum of Care Program does not exist for our "defined population," therefore the baseline for number of participants begins at 0 in DY2.

Rationale:

Child and Adolescent Wraparound Services: Only 41.7 of children ages 2 to 17 in Texas received the mental health care that they need.[36] Wraparound services are considered among the most effective interventions for children with emotional, behavioral and mental health needs, who make substantial improvements when provided wraparound services instead of institutional care, including that they: *Have fewer arrests and stays in detention; Are hospitalized less often; Sustain their mental health improvements; Have less suicidal behavior; and Have better school attendance and achievement.* The Surgeon General has embraced the effectiveness of community-based services like wraparound services, both in the Surgeon General's *Report on Mental Health* and the *Report on Youth Violence*. Wraparound services not only have better outcomes but also cost far less than more restrictive institutional and group care. Individual outcomes for children/families participating in wraparound services improve, including decreased behavioral concerns; improved academic performance; and decreased contacts with the juvenile justice system.

***30 Day Intensive outpatient Treatment*:** People with untreated mental illnesses often use street drugs as self-medication. Homeless people with both substance disorders and mental illness experience additional obstacles to recovery, such as increased risk for violence and victimization and frequent cycling between the streets, jails, and emergency rooms.[37] Many behavioral health programs for homeless people do not accept people with substance abuse disorders, and many substance abuse programs for homeless do not treat people with mental illness. There are no programs in the Amarillo area that provide intensive outpatient substance abuse/behavioral health services targeting the Amarillo homeless population who are mentally ill and/or are substance abusers.

***Criminal Justice Diversion*:** In Texas, and all across the United States, a broad systemic problem has evolved over the years: *the overrepresentation of people with mental illnesses who come into contact with the criminal justice system*. According to a 1999 U.S. Department of Justice study, the prevalence of mental illness is three to four times higher among inmates in jail and prison than in the general population. Almost half of inmates with mental illnesses are incarcerated for non-violent crimes.

the Continuum of Care Program will address both Critical Needs identified in the RHP 12 Needs Assessment Summary- Community Needs Identification: CN.1 *(*wait time, lack of insurance, access to care) and **CN.2** (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as other community needs CN.8 (Alcohol abuse and binge drinking, substance abuse) and CN.9 (Tobacco use). The CoC Program will be implemented under Project Option 2.13.1 of the RHP Planning Protocol and will address all required project components as outlined under project options (as listed below)

[36] RHP 12 Needs Assessment Summary

[37] Fisher, G.L., ed., and Roget, N.A., ed. Encyclopedia of Substance Abuse Prevention, Treatment, and Recovery. 2009. SAGE Publications, Inc.

a) *Assess size, characteristics and needs of target population(s).* Stakeholder meetings, statistical analysis, etc will be conducted to determine size, characteristics and needs of consumers.

b) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Best practices will be determined through these reviews and practices implemented where feasible.

c) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* This will be done during planning phase.

d) *Design models which include an appropriate range of community-based services and residential supports.* Previous experience, current treatment gaps, stakeholder involvement, best practices will all be part of this process.

e) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* Research will be conducted to determine the best quantitative measures to use and qualitative analysis of this date will be used to improve program.

Process Milestones – DY2 and DY3: These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P- 2 Establish baseline rates

Improvement Target – DY4 and DY5

IT-10.1 Quality of Life (*Standalone measure)*

a. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population.
b. Data source: A validated assessment tool for quality of life will be chosen as part of the planning process in year one. Validation assessment tools that will be vetted include AQoL, SF-36, 20 or 12, DSHS assessments, and similar assessment tools.
c. Rationale/Evidence: In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Unique community need identification numbers the project addresses:
CN.1- Wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact; CN.3- Poor insurance support or uninsured; CN.8- Alcohol abuse and binge drinking, substance abuse; and CN.9- Tobacco use

How the project represents a new initiative or significantly enhances an existing reform initiative:
The 3 major components of this project address critical behavioral health needs. There is currently no 30 day outpatient treatment program in the local service area; the criminal justice diversion program addresses gaps that persons with behavioral health needs fall through. There has been a wraparound service delivery model for children in Amarillo (Safe Schools/Healthy Students) that has proven effective, but the grant cycle for that program has run out. The Child and Adolescent Wraparound Services Program will incorporate the best aspects of that program, along with best practices that have proven effective elsewhere, and expanding the program to other school districts.

Related Category 3 Outcome Measure(s): *OD- 10 Quality Of Life/ Functional Status:* The Continuum of Care Program will provide needed behavioral health services/interventions that will improve quality of life to those in need, so we believe that measuring for improvement in quality of life can help shape services to be even more effective. The CoC Program has been shaped around Critical Needs identified in the RHP 12 Needs Assessment Survey The vast majority of the target population for the CoC Program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Relationship to other Projects: The CoC Program will support, enable, and relate to other projects in the RHP plan as listed below:
127378105.1.1 Crisis Respite- persons served in the CoC Program can be immediately referred to Crisis Respite if the need is determined. The CoC Program will also be a resource for persons being served by Crisis Respite.
*127378105.2.2 Integrate Primary and Behavioral Health Care Services***-** persons served by the CoC Program who have behavioral and primary health care needs will have improved access to integrated primary and behavioral healthcare through provision of this project. Also, persons served in the integrated healthcare setting can be immediately referred to CoC services if the need is determined during integrated care appointments.
Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-

to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	This project achieves all of the following waiver goals: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth The project primarily impacts Medicaid and/or uninsured residents. The expected impact is very significant, as it addresses "cracks in the system" that need to be addressed. There strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**5**
Addresses Community Need(s)	This project addresses the largest number of community needs as related to our other projects. Unique community need identification numbers the project addresses include: *CN.1- Wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact*; *CN.3- Poor insurance support or uninsured; CN.8- Alcohol abuse and binge drinking, substance abuse; and CN.9- Tobacco use*	**5**
Project Scope/Size	This is TPC's largest project as related to: the potential population that will be reached; the number of consumer visits/encounters; the number of individual providers recruited/trained, and the savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**5**
Project Investment	Relative to our other proposed projects, the expected investment to successfully implement this project and achieve milestones and metrics is expected to be our largest. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**5**

127378105.2.1	2.13.1	2.13.1.a-e	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Texas Panhandle Centers			**127378105**

Related Category 3 Outcome Measure(s):	**127378105.3.2**	**IT-10.1**	**Quality of Life- Standalone measure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-2. Milestone: Design community-based specialized interventions for target populations. P-2.1. Metric: Project plans which are based on evidence / experience and which address the project goals. Goal: Produce a comprehensive report documenting project plans above. Data Source: Project documentation Milestone 1 Estimated Incentive Payment: $1,334,213	P-3. Milestone: Enroll and serve individuals with targeted complex needs P-3.1. Metric: Number of targeted individuals enrolled / served in the project. Baseline: At the beginning of DY2, CoC program did not exist; therefore, baseline for all is 0. Goal: Enroll 785 unique individuals in the CoC program. • Wraparound Services:700 • Outpatient Program:60 • Diversion Program: 25 Data source: Project documentation Milestone 2 Estimated Incentive Payment: $1,465,131	P-3. Milestone: Enroll and serve individuals with targeted complex needs P-3.1. Metric: Number of targeted individuals enrolled / served in the project. Goal: Enroll 850 unique individuals in the CoC program. • Wraparound Services:750 • Outpatient Program:70 • Diversion Program: 30 Data source: Project documentation Milestone 3 Estimated Incentive Payment: $783,674 I-1. Milestone: Criminal Justice Admissions/Readmissions I-1.1. Metric: The percentage of decrease in preventable admissions and readmissions into Criminal Justice System. Goal: 5% decrease in preventable admissions and readmissions into Criminal Justice System of adults and	P-3. Milestone: Enroll and serve individuals with targeted complex needs P-3.1. Metric: Number of targeted individuals enrolled / served in the project. Goal: Enroll 915 unique individuals in the CoC program. • Wraparound Services:800 • Outpatient Program:80 • Diversion Program: 35 Data source: Project documentation Milestone 5 Estimated Incentive Payment: $757,174 I-1. Milestone: Criminal Justice Admissions/Readmissions I-1.1. Metric: The percentage of decrease in preventable admissions and readmissions into Criminal Justice System. Goal: 6% decrease in preventable admissions and readmissions into Criminal Justice System of adults and

127378105.2.1	2.13.1	2.13.1.a-e	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Texas Panhandle Centers			**127378105**
Related Category 3 Outcome Measure(s):	**127378105.3.2**	**IT-10.1**	**Quality of Life- Standalone measure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
		youth receiving specialized interventions that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, youth detention, etc.) within the measurement period. Data Source: Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records, school records. Milestone 4 Estimated Incentive Payment: $783,675	youth receiving specialized interventions that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, youth detention, etc.) within the measurement period. Data Source: Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records, school records. Milestone 6 Estimated Incentive Payment: $757,173
*DY 2 Estimated Milestone Bundle Amount: $*1,334,213	DY 3 Estimated Milestone Bundle Amount:$1,465,131	DY4 Estimated Milestone Bundle Amount: $1,567,349	*DY5 Estimated Milestone Bundle Amount: $1,514,347*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $5,881,040			

Project Option: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Performing Provider: Texas Panhandle Centers Behavioral and Developmental Health / 127378105
RHP Unique Identification Number: 127378105.2.2

- Provider: Texas Panhandle Centers Behavioral and Developmental Health is a local mental health authority providing behavioral and developmental health services in the top 21 counties of the Texas Panhandle, an area of over 21,000 square miles with a population of approximately 400,000.
- Intervention(s): Provision of coordinated and integrated primary and behavioral health services for the first time in the Amarillo, TX area through the co-location of primary care medical services and community-based behavioral health services in at least two (2) sites in the Amarillo, Texas area.
- Need for the project: Integrated care has never been provided in the local service area. *This project meets both of the Critical Needs outlined in the RHP 12 Needs Assessment Summary under community needs (*CN.1-Severe primary care provider shortage, wait time, lack of insurance, access to care and CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact)*, along with Urgent Need* CN.3- Poor insurance support or uninsured.
- Target population: The target population is adults with both behavioral health needs and primary care needs in the top 21 counties of the Texas Panhandle. Approximately 90% of our clients are either Medicaid eligible or indigent. We anticipate enrolling 111 patients in DY3, 133 patients in DY4, and 250 patients in DY5
- Category 1 or 2 expected patient benefits: 111 individuals will receive both physical and behavioral health care at the established locations over the baseline (0) in DY3, 133 individuals will receive both physical and behavioral health care at the established locations over the baseline (0) in DY4, and 250 individuals will receive both physical and behavioral health care at the established locations over the baseline (0) in DY5.
- Category 3 outcomes: IT-10.1 Our goal is to demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD %

Project Option: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

Performing Provider: Texas Panhandle Centers Behavioral and Developmental Health / 127378105

RHP Unique Identification Number: 127378105.2.2

Project Components: 2.15.1.a-j

Project Description: Texas Panhandle Centers Behavioral and Developmental Health (TPC), as a provider of behavioral health services to children and adults across the top 21 counties of the Texas Panhandle, proposes to provide coordinated and integrated primary and behavioral health services for the first time in the Amarillo, TX area through the co-location of primary care medical services and community-based behavioral health services. TPC plans to partner with a regional health care provider to implement this project, and use the National Council for Community Behavioral Health Four Quadrant Clinical Integration Model to consider subsets of the population, the major system elements, and clinical roles. Patients with concomitant mental health and primary care needs will receive care in a more integrated model, resulting in improved patient outcomes and experiences. In addition, this integration will enhance the work life of primary care and behavioral health providers and staff by facilitating their ability to obtain needed services for their patients in a more coordinated and accessible manner. Primary care and behavioral health providers will share the same facility and have some systems in common, have regular face-to-face communication, and use a team approach.

Goals and Relationship to Regional Goals:

Project Goals: The goals of this project include:

- Using primary health care staff, case managers, social workers, and others to provide coordinated and integrated primary and behavioral health services for the first time in the Amarillo, TX area through the co-location of primary care medical services and community-based behavioral health services in at least two (2) sites in the Amarillo, Texas area. There are currently no integrated primary and behavioral health care providers in the local service area (top 21 counties of Texas.
- Increase percentage of individuals receiving both physical and behavioral health care at the established locations.
- Demonstrate improvement in quality of life, as measured by an evidence-based and validated assessment tool, for the target population.

This project meets the following regional goals:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

*This project meets both of the Critical Needs outlined in the RHP 12 Needs Assessment Summary under community needs (*CN.1- Severe primary care provider shortage, wait time, lack of insurance, access to care and CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact)*, along with Urgent Need* CN.3- Poor insurance support or uninsured. The vast majority of the target population for this program are low income; *92% of current TPC clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Qualified Mental Health Professionals (QMHPs) to help and support these patients to navigate through the continuum of integrated health care services while receiving services in the program. QMHPs will ensure that patients receive coordinated, timely, and site-appropriate services. QMHPs may assist in connecting patients to other service providers in the local service area, as well as diverting those who do not qualify for service in the program to appropriate referrals.

Challenges:

The primary challenge for this project will be to engage and build trust with patients. Targeted communities have historically been difficult to penetrate, but with proper navigator training and effective procedures, the project will be successful. In particular, cultural competency training and the involvement of a variety of innovative provider types within the care team that can address the full spectrum of the participants' needs will facilitate patient engagement.

5-Year Expected Outcome for Provider and Patients:

TPC expects to implement integrated physical and behavioral healthcare in two (2) sites in the Amarillo area. TPC expects to see improvements in quality of life outcomes for patients enrolled in the program and delivered within the local service area. The provider expects to improve outcomes within the system and community outreach in targeted zip codes. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline: There is not a program of this type in the local service area; therefore, the baseline will be 0 in DY2

Rationale: This project represents a new initiative for Texas Panhandle Centers as the Performing Provider, as integrated care has never been provided in the local service area. The need for linkage between behavioral health and primary care is evident on several fronts:

- People with chronic medical illnesses are more likely to experience mental illness.
- Individuals with severe mental illness have higher rates of hypertension, cardiovascular disease, HIV/AIDS, metabolic syndrome, obesity, diabetes, and early mortality.
- Co-morbidity of mental health issues and chronic illness is associated with poor medication adherence, inability to follow treatment regimens and increased use of emergency rooms**.**
- Anti-psychotic medications have been linked with side effects such as obesity, high blood glucose levels, and diabetes.
- People who have mental illnesses are more likely to have sedentary lifestyles and/or abuse alcohol, cigarettes, and/or drugs, leading to exacerbated health conditions.
- Many patients with behavioral health conditions using primary care clinics do not receive co-management from a behavioral health professional. At the same time, many patients receiving care at behavioral health clinics do not have a primary care provider.

This project will be implemented under Project Option 2.15.1 of the RHP Planning Protocol and will address all project components:

a) *TPC will identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.* Ease of access, centralized locations, etc. will all be factors.

b) *Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.* Other successful integrated care sites will be used as models for this.

c) *Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.* Other successful integrated care sites, such as programs in Lubbock, TX and Austin, TX, will be used as models for this.

d) *Recruit a number of specialty providers to provide services in the specified locations.* This will be done in conjunction with partner agencies.

e) *Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include: Regular consultative meetings between physical health and behavioral health practitioners; Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or Shared treatment plans co-developed by both physical health and behavioral health practitioners.* Other successful integrated care sites will be used as models for this.

f) *Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting.* Other successful integrated care sites will be used as models for this.

g) *Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.*

h) *Arrange for utilities and building services for these settings.* Research into this has already begun.

i) *Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.* Other successful integrated care sites will be used as models for this.

j) *Conduct quality improvement for project using methods such as rapid cycle improvement.* This will be planned in conjunction with primary health care partners.

Milestones and Metrics: Milestones and metrics will be based on relevancy to RHP 12's population and circumstances, community need, and RHP 12's priority and starting point. The process milestone of "Develop integrated behavioral health and primary care services within co-located sites" will measure the growth of new integration sites, several of which are being researched that will each address different patient populations of the Four Quadrant Clinical Integration Model.

Process Milestones – DY2 and DY3:

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P- 2 Establish baseline rates

Improvement Target – DY4 and DY5

- IT-10.1 Quality of Life (*Standalone measure)*
    d. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population.
    e. Data source: A validated assessment tool for quality of life will be chosen as part of the planning process in year one. Validation assessment tools that will be vetted include AQoL, SF-36, 20 or 12, DSHS assessments, and similar assessment tools.
    f. Rationale/Evidence: In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

COMMUNITY NEEDS IDENTIFICATION:
CN.1-Severe primary care provider shortage, wait time, lack of insurance, access to care and
CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact).
CN.3- Poor insurance support or uninsured.

Related Category 3 Outcome Measure(s): *OD- 10 Quality Of Life/ Functional Status:*
IT-10.1 Quality of Life (*Standalone measure)*

g. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population.
h. Data source: A validated assessment tool for quality of life will be chosen as part of the planning process in year one. Validation assessment tools that will be vetted include AQoL, SF-36, 20 or 12, DSHS assessments, and similar assessment tools.
i. Rationale/Evidence: In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Reasons/rationale for selecting the outcome measures: This Primary and Behavioral Health Integration Project, shaped around the two critical Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving patient's quality of life as related to health, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion.

Relationship to other Projects: This project will support, enable, and relate to other projects in the RHP plan as listed below:

127378105.2.1 Continuum of Care Program(Child and Adolescent Wraparound Services Program, Intensive Outpatient Treatment Program, and the Criminal Justice Diversion Program)- persons served under the Continuum of Care program who have behavioral and primary health care needs will have improved access to integrated primary and behavioral healthcare through provision of this program. Also, persons served in the integrated healthcare setting can be immediately referred to Continuum of Care services if the need is determined during integrated care appointments.

127378105.1.1 Crisis Respite- persons served in Crisis Respite who have behavioral and primary health care needs will have improved access to integrated primary and behavioral healthcare through provision of this program. Also, persons served in the integrated healthcare setting can be immediately referred to Crisis Respite if the need is determined during integrated care appointments.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Relative to TPC's other proposed projects, this project ties with the highest ranking of achieving the waiver goals of: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improving the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; further developing and maintaining a coordinated care delivery system; and improving outcomes while containing cost growth. The project impact all of the goals; it primarily impact Medicaid and/or uninsured residents; the expected impact is significant; and there is strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**5**
Addresses Community Need(s)	This project addresses the second largest number of community needs as related to our other projects. This project addresses the following community needs identified in the RHP 12 Needs Assessment Summary: CN.1-Severe primary care provider shortage, wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact); and CN.3- Poor insurance support or uninsured.	**4**
Project Scope/Size	We believe this project will be our second largest relative to our other projects in terms of scope/size. We took into account improvements/increases in: Outreach to the targeted population; Patient visits/encounters; Providers recruited/trained; and Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**4**
Project Investment	Relative to our other proposed projects, the expected investment to successfully implement this project and achieve milestones and metrics will be the second largest. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**4**

127378105.2.2	2.15.1	2.15.1.a-j	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Texas Panhandle Centers			**127378105**

Related Category 3 Outcome Measures):	**127378105.3.3**	**IT-10.1**	**Quality of Life- Standalone measure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
P-2. Milestone: Identify existing clinics or other community-based settings where integration could be supported. P-2.1. Metric: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. Goal: Produce a comprehensive report documenting process above. Data Source: Information from discussions/persons interviewed Milestone 1 Estimated Incentive Payment: $1,134,081	P.6 Milestone: Develop integrated behavioral health and primary care services within co-located sites. P-6.1. Metric: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Baseline: At the beginning of DY2, integrated behavioral health and primary care services did not exist; therefore, baseline for all is 0. Goal: Work with primary care provider to co-locate services in 1 site and serve 111 patients. Data Source: Project data Milestone 2 Estimated Incentive Payment: $1,245,361	~~nd~~ I-8. Milestone: Integrated Services I-8.1. Metric: Percent of Individuals receiving both physical and behavioral health care at the established locations. Goal: Provide both physical and behavioral health care to 133 individuals receiving services in project sites Data Source: Project data; claims and encounter data; medical records Milestone 3 Estimated Incentive Payment: $1,332,247	P.6 Milestone: Develop integrated behavioral health and primary care services within co-located sites. P-6.1. Metric: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Goal: Work with primary care provider to co-locate services in 2nd site. Data Source: Project data Milestone 4 Estimated Incentive Payment: $643,597.50 I-8. Milestone: Integrated Services I-8.1. Metric: Percent of Individuals receiving both physical and behavioral health care at the established locations. Goal: Provide both physical and behavioral health care to 250 individuals receiving services in

127378105.2.2	2.15.1	2.15.1.a-j	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Texas Panhandle Centers			**127378105**
Related Category 3 Outcome Measures):	**127378105.3.3**	**IT-10.1**	**Quality of Life- Standalone measure**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
			project sites Data Source: Project data; claims and encounter data; medical records Milestone 5 Estimated Incentive Payment: $643,597.50
DY 2 Estimated Milestone Bundle Amount: $1,134,081	DY 3 Estimated Milestone Bundle Amount: $1,245,361	DY4 Estimated Milestone Bundle Amount: $1,332,247	*DY5 Estimated Milestone Bundle Amount: $1,287,195*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,998,884			

Project Option: 2.18.1 Design, implements, and evaluates whole health peer support for individuals with mental health and /or substance use disorders.
Performing Provider / TPI: Texas Panhandle Centers Behavioral and Developmental Health / 127378105
RHP Unique Identification Number: 127378105.2.3 – **"Pass 2"**

- Provider: Texas Panhandle Centers Behavioral and Developmental Health is a local mental health authority providing behavioral and developmental health services in the top 21 counties of the Texas Panhandle, an area of over 21,000 square miles with a population of approximately 400,000.
- Intervention(s): A Peer Support program that uses consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services.
- Need for the project: The Peer Support Program will address both Critical Needs identified in the RHP 12 Needs Assessment Summary- CN.1 (wait time, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as CN.9 (Tobacco use). This project will significantly enhance peer support services available in the local service area.
- Target population: The target population is adults with behavioral health needs in the top 21 counties of the Texas Panhandle. Approximately 90% of our clients are either Medicaid eligible or indigent.
- Category 1 or 2 expected patient benefits: The project seeks in mprovement in standardized health measures for 25% of consumers who participate in whole health peer support in DY4, and 30% of consumers in DY5.
- Category 3 outcomes: IT-10.1 Our goal is to demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD %

Project Option: 2.18.1 *Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.*

Performing Provider / TPI: *Texas Panhandle Centers Behavioral and Developmental Health / 127378105*

RHP Unique Identification Number: *127378105.2.3*

Project Components: *2.18.1.a-i*

Project Description: Peer Support Program- Texas Panhandle Centers Behavioral and Developmental Health, as a provider of behavioral health services to children and adults across the top 21 counties of the Texas Panhandle, proposes to implement a Peer Support program that uses consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services. Building on a project (Via Hope) originally established under the State's Mental Health Transformation grant that our Center has been a part of, consumers will be trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training will be provided to certified peers specialists in "whole health". With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes and COPD.

Texas Panhandle Centers Behavioral and Developmental Health is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health and intellectual and developmental disabilities for the established service area. Texas Panhandle Centers provides mental health services in 21 counties in the RHP 12 area. Helen Farabee Center is also a community center operating under the same provisions as Texas Panhandle Centers, but serving a completely different geographic area within RHP 12. There is no overlap of service areas between the two centers. Helen Farabee has proposed several 1115 Waiver projects, but was unable to utilize their full DSRIP allocation in Pass 2 for RHP 12. In order to assist further in transformational activities related to behavioral health they provided Texas Panhandle Centers with a portion of their unused DSRIP in the amount of $ 26,033. Texas Panhandle Centers has included this allocation with TPC's Pass 2 project allocation and will be providing the IGT required for the total of the two. TPC's Pass 2 Project: Peer Support will design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders *for the TPC service area only.* Texas Panhandle Centers and Helen Farabee Center are both publically funded governmental entities. For this reason Texas Panhandle Centers does not believe the DSRIP funds provided to TPC by Helen Farabee meet the definition of a provider relation donation as defined by HHSC 's IGT Guidelines.

Goals and Relationship to Regional Goals: The goal of this project is to use consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services.

This project meets the following regional goals:
The CoC Program will reach the RHP 12 Triple Aim Goals of assuring patients receive high-quality and patient-centered care in the most cost-effective ways. Intervening and treating a person before they are incarcerated or hospitalized is much more cost effective. The Continuum of Care Program will address a Critical Need identified in the RHP 12 Needs Assessment Summary- Community Needs Identification: CN.1 (wait time, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact), as well as other community needs CN.8 (Alcohol abuse and binge drinking, substance abuse) and CN.9 (Tobacco use).

Challenges: While peer support training currently exists, very limited numbers of peers are trained due to resource limitations. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population ("Morbidity and Mortality in People with Serious Mental Illness", National Association of State Mental Health Program Directors, 2006.)), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase ("Mental Disorders and Medical Co-Morbidity." Robert Wood Johnson Foundation, The Synthesis Project: Issue 21 (2011)).

5-Year Expected Outcome: Texas Panhandle Centers expects that through the development of a peer support program, local services will become more recovery-oriented, strengths-based, person centered and focused on resilience.

Starting Point: The baseline will be determined in DY2 as part of the planning process

Rationale:
One of the greatest resources for people in recovery is the support offered by their peers.[38] Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness (The HARP Program: A peer-led intervention to improve medical self-management for persons with serious mental illness, Schizophrenia Research, May 2010). Region 12 has a severe shortage of mental health services[39]; peer support is an important tool in addressing this issue.

[38] http://www.dbhids.org/peer-support
[39] RHP 12 Needs Assessment Summary

The project will meet all of the required core components:

a) *Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.* This will be done using materials received through collaboration with Via Hope.
b) *Conduct readiness assessments of organization that will integrate peer specialists into their network.* Weaknesses will be identified through assessment informed by Via Hope collaboration. Some weaknesses have already been identified through Via Hope collaboration, such as not enough peer input into service delivery planning.
c) *Identify peer specialists interested in this type of work.* The Center will work with the local NAMI chapter and the Amarillo Area Mental Health Consumers (a local independent peer support organization) to identify prospective peer specialists.
d) *Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity.* These program interventions will be used to enhance and support services provided in all projects we are proposing, including our integrated health care program, continuum of care program, and crisis respite program. Our Center is also going tobacco free; this project will provide needed support for clients.
e) *Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.* These assessments will be added to intake and update packets for behavioral health clients, and completed at the same time as intakes and updates.
f) *Identify patients with serious mental illness who have health risk factors that can be modified.* These clients will be identified through the use of health assessments as described above.
g) *Implement whole health peer support.* Will develop individual as well as group support, using peers as educators and encouragers.
h) *Connect patients to primary care and preventive services.* Patients who have health needs identified through assessments and other means will be linked to a nurse case manager, who will refer to needed resources, including the Center's integrated Health Program (Project TPI:[127378105]2.15.1).
i) *Track patient outcomes. Review the intervention(s) impact on participants and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* This will include a cross disciple evaluation of data by staff/stakeholders.

Process Milestones – DY2 and DY3: These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P- 2 Establish baseline rates

Improvement Target – DY4 and DY5

IT-10.1 Quality of Life (*Standalone measure)*

j. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population.
k. Data source: A validated assessment tool for quality of life will be chosen as part of the planning process in year one. Validation assessment tools that will be vetted include AQoL, SF-36, 20 or 12, DSHS assessments, and similar assessment tools.
l. Rationale/Evidence: In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Unique community needs identification numbers the project addresses:

- CN.1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care
- CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact.
- CN.9- Tobacco Use

How the project represents a new initiative or significantly enhances an existing reform initiative:

This project will significantly enhance peer support services available in the local service area.

Related Category 3 Outcome Measure(s): *OD- 10 Quality Of Life/ Functional Status:* The basic idea of the Crisis Respite Project is providing needed behavioral health services and interventions that will improve quality of life to those in need, so we believe that measuring for improvement in quality of life can help shape services provided to be even more effective. The project has been shaped around a Critical Need identified in the RHP 12 Needs Assessment Survey The vast majority of the target population for this program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Process Milestones – DY2 and DY3: These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P- 2 Establish baseline rates

Improvement Target – DY4 and DY5

- IT-10.1 Quality of Life (*Standalone measure)*
    m. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence based and validated assessment tool, for the target population.
    n. Data source: A validated assessment tool for quality of life will be chosen as part of the planning process in year one. Validation assessment tools that will be vetted include AQoL, SF-36, 20 or 12, DSHS assessments, and similar assessment tools.
    o. Rationale/Evidence: In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Relationship to other Projects: This project will support, enable, and relate to other projects in the RHP plan as listed below:
TPI: 127378105.2.2 *Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.(Continuum of Care Project)-* persons served in the Peer Support project can be immediately referred to Crisis Respite if the need is determined. The Peer Support will also be a resource for persons being served by Crisis Respite.
TPI: 127378105.2.1 *Integrate Primary and Behavioral Health Care Services***-** persons served through the Peer Support program who have behavioral and primary health care needs will have improved access to integrated primary and behavioral healthcare through provision of this program. Also, persons served in the integrated healthcare setting can be immediately referred to Peer Support services if the need/appropriateness is determined during integrated care appointments.

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways

they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways • Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties • Further develop and maintain a coordinated care delivery system • Improve outcomes while containing cost growth Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project impact one or more of the goals? • Does the project primarily impact Medicaid and/or uninsured residents? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**3**
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project address one or more community need? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**3**

Project Scope/Size	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in • Outreach to the targeted population • Patient visits/encounters • Providers recruited/trained • Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**
Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: • Human resources • Equipment purchase and maintenance • Legal and professional fees • Time to implement • Risk assessment • Organizational priorities	**2**

127378105.2.3	**2.18.1**	**2.18.1.a-i**	*Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.*
Texas Panhandle Centers			**127378105**
Related Category 3 Outcome Measure(s):	**12738105.3.4**	**IT-10.1**	**Quality of Life**

DY 2 (10/1/2012-9/30/2013)	***DY 3 (10/1/2013-9/30/2014)***	***DY 4 (10/1/2014-9/30/2015)***	***DY 5 (10/1/2015-9/30/2016)***
P-1. Milestone: Train administrators and key clinicians (e.g. PCP, BH clinicians) on: • Understanding what recovery/wellness is and that it is possible • Understanding the value of peer specialists and peer support workers • Understanding how to integrate and support peer workers in their organizations P-1.1. Metric: Number of staff trained Baseline: At the beginning of DY2, peer support did not exist; therefore, baseline for all is 0 Goal: Develop the training program and train 25 staff. Data Source: Staff rosters and training records, Training curricula **Milestone 1 Estimated Incentive Payment:** $263,062	P-6. Milestone: Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors. P-6.1. Metric: Number of participants receiving peer services. Baseline: At the beginning of DY2, peer support did not exist; therefore, baseline for all is 0 Goal: Provide peer services to 200 consumers. Data Source: Internal records and clinical records **Milestone 3 Estimated Incentive Payment:** $276,537 I-18. Milestone: Health Outcomes I-18.1. Metric: Improvements in standardized health measures for	I-18. Milestone: Health Outcomes I-18.1. Metric: Improvements in standardized health measures for consumers who participate in whole health peer support Goal: Improvement in standardized health measures for 25% of consumers who participate in whole health peer support Data Source: Project Data; Medical Record Data; Participant Surveys; **Milestone 5 Estimated Incentive Payment:**$ 531,762	I-18. Milestone: Health Outcomes I-18.1. Metric: Improvements in standardized health measures for consumers who participate in whole health peer support Goal: Improvement in standardized health measures for 30% of consumers who participate in whole health peer support Data Source: Project Data; Medical Record Data; Participant Surveys; **Milestone 6 Estimated Incentive Payment:**$ 438,027

P-3. Milestone: Identify and train peer specialists to conduct whole health classes. P-3.1. Metric: Number of peers trained in whole health planning Baseline: At the beginning of DY2, peer support did not exist; therefore, baseline for all is 0 Goal: Develop the training program and train 3 peer specialists Data Source: Training records **Milestone 2 Estimated Incentive Payment:** $263,061	consumers who participate in whole health peer support Goal: Improvement in standardized health measures for 20% of consumers who participate in whole health peer support Data Source: Project Data; Medical Record Data; Participant Surveys; **Milestone 4 Estimated Incentive Payment:** $ 276,536		
Year 2 Estimated Total DSRIP: $526,123	Year 3 Estimated Total DSRIP: $553,072	Year 4 Estimated Total DSRIP: $531,762	Year 5 Estimated Total DSRIP: $438,027
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):$2,048,986			

Project Option: 2.1.1 Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
Performing Provider Name/TPI: Texas Tech University Health Sciences Center – Amarillo/ 084563802
Unique Project ID: 084563802.2.1
Project Components: 2.1.1.a-d

- **Provider:** Texas Tech University Health Sciences Center- Amarillo, Department of Pediatrics, is the largest provider of pediatric Medicaid services in the northern Texas Panhandle. We serve an immediate community of approximately 250,000 in the Amarillo metropolitan area. Additionally, we serve as the primary referral center for pediatric services in the northern 26 counties of the Texas Panhandle. Our pediatric clinic performs approximately 40,000 clinical encounters per year, 75% of which are to financially disadvantaged children.
- **Intervention(s):** This project transforms the delivery of patient care in our clinic to a patient-centered, preventive-minded focus by implementation of the patient-centered medical home model.
- **Need for the project:** There are currently no NCQA 2011 standard-certified medical homes in the Texas Panhandle. Many of our patients are disenfranchised with the medical system, and thus utilize high cost and inappropriate health care venues for issues that could be better handled at the primary care level.
- **Target population:** Our target population is our pediatric clinic patient panel. We have more than 8000 unique patients served at our clinic. Currently 75% of our patient population either have Medicaid funding or are indigent.
- **Category 1 expected patient benefits:** We will achieve NCQA patient-centered medical home certification by DY 5. This certification serves as a validation of our efforts to improve patient access, focus on preventive care services, appropriately incorporate technology in healthcare delivery and identify and target high risk populations within our clinic.
- **Category 3 outcomes:** Our goal is to improve patient satisfaction with clinical services provided as measured by a standardized satisfaction survey by 5% in 40% of satisfaction domains by year DY5.

Project Option: 2.1.1 Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
Performing Provider Name/TPI: Texas Tech University Health Sciences Center – Amarillo/ 084563802
Unique Project ID: 084563802.2.1
Project Components: 2.1.1.a-d
Project Description:

The goal of this project is to expand and enhance the delivery of care provided through the Patient Centered Medical Home (PCMH) model. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care. Our main pediatric clinic sees about 20,000 primary care patient encounters per year and has more than 8000 patients in our practice. 75% of our patient population is economically disadvantaged. Financial, language, and cultural barriers may prevent optimum access to primary medical care and disease management, resulting in increased inappropriate utilization of higher cost emergency department or hospital based care. There are several challenges that we face in implementing a medical home model. Economically disadvantaged patients typically have a lower level of healthcare literacy and may have more difficulty accessing community resources and navigating the complex healthcare delivery system. Likewise, patient financial strains make it difficult for the primary care physician to be able to contact some patients as addresses, phone numbers, and contact information may change frequently. Increased regulatory requirements from Medicaid contractors decrease the amount of time available for providers to actively see patients. Implementation of an effective case management program will be an essential component of overcoming these challenges. As an academic institution, clinic assignments have been historically made based on the educational needs of the learners. Balancing the sometimes disparate requirements of our academic mission with the individual needs of our patients for optimum care delivery and system requirements for cost efficiency is difficult. Provider and staff education regarding the concepts and precepts of a PCMH can develop staff and provider investment in the project. This will be a springboard for changing historical perspectives of the academic clinic design. Over the course of the 5 year project, we anticipate performing a gap analysis, hiring clinic case managers and filling other deficits noted in the gap analysis, and attaining NCQA PCMH certification by the 5th year of this demonstration project. It is anticipated that this project will result in higher quality and more cost effective health care delivery centered on the individual patient's unique needs and circumstances.

Project Goals:

The goal of this project is to expand and enhance the delivery of care provided through the Patient Centered Medical Home (PCMH) model. It is anticipated that this project will result in higher quality and more cost effective health care delivery centered on the individual patient's unique needs and circumstances.

This project meets the following regional goals:

Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:

Economically disadvantaged patients typically have a lower level of healthcare literacy and may have more difficulty accessing community resources and navigating the complex healthcare delivery system. Likewise, patient financial strains make it difficult for the primary care physician to be able to contact some patients as addresses, phone numbers, and contact information may change frequently. Increased regulatory requirements from Medicaid contractors decrease the amount of time available for providers to actively see patients.

5-Year Expected Outcome from Provider and Patients:

Over the course of the 5 year project, we anticipate performing a gap analysis, hiring clinic case managers and filling other deficits noted in the gap analysis, and attaining NCQA PCMH certification by the 5th year of this demonstration project.

Starting Point/ Baseline:

Seven general pediatricians, three midlevel providers and seventeen resident physicians serve more than 7000 patients with 20,000 patient encounters between September 2011 and August 2012. There are currently no certified PCMH in the northern Texas Panhandle. No providers or staff has been trained on the concept or specifics of the PCMH implementation.

Rationale:

Federal, state, and health care providers share goals to promote more patient centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over utilization. This project will establish a foundation for transforming the primary care landscape in the Texas Panhandle by emphasizing enhanced chronic disease management through team based care. Access to primary care was defined as a critical issue in our community. This project primarily addresses Community Needs Assessment Need CN1 (severe problems with access to primary care) but also would directly improve CN 10 (improvement in asthma care) and CN 11 (improvement in vaccination rates). Although not intuitive in a pediatric patient population, effective pediatric healthcare delivery with a focus on preventive care could substantially affect the long term rates of diabetes, heart disease and obesity (CN.4). We have a community rate of overweight and obesity of 61%. Prevention of these chronic illnesses by improved intervention in children could help attenuate the crippling long term costs of management of these diseases.

The rationale for selection of individual milestones is as follows:

P□3. Milestone: Reorganize staff into primary care teams responsible for the coordination of patient care.
Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence□based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions. It is clear that primary care physicians in the 15□minute visit can no longer do what their patients expect and deserve." Our clinic is currently modeled according to the old paradigm of an acute problem being dealt with in a 15 minute visit. With a modern focus on improving cost effectiveness and health care quality by focusing on preventive care, this old model is no longer viable.
P□5. Milestone: Determine the appropriate panel size for primary care provider teams.
Rationale/Evidence: Panel size analysis could support panel management decisions as clinics approach population management. Our patient assignment methodology must evolve past merely assigning a patient based on provider availability. "At the heart of the Patient Centered Medical Home model is the relationship between a patient and a provider and his/her practice team. All the activities of an effective patient centered medical home should strengthen and reinforce the primacy of that relationship, and its accountability for the patient's care. The positive impacts of seeing the same provider on patient experience, clinical care, and outcomes have been unequivocally demonstrated by research and practice." Determining the appropriate panel size, individualized to the provider and specific to the needs of the patient will improve the therapeutic relationship between patient and healthcare team.
P□7. Milestone: Track the assignment of patients to the designated care team. Rationale/Evidence: Review panel status (open/closed) and panel fill rates on a monthly basis for equity to be able to adjust to changing environment (e.g., patient preference, extended provider leave). With different provider types (part-time, full time, resident physicians, mid-level providers) patient panels will need to be tracked and adjusted on an ongoing basis. We anticipate this will continue through the end of the project demonstration.
P-13 Quality Improvement Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self□reported data and sampling that is sufficient for the purposes of improvement.
Rationale/Evidence: The rate of testing of new solutions and ideas is one of the greatest predictors of the success of a health care system's improvement efforts.
I-18 Milestone: Obtain medical home recognition (PCMH 2011 Recognition) by a nationally recognized agency (e.g., NCQA).
Rationale/Evidence: It is important to validate the medical home service being provided by seeking and receiving recognition/accreditation. Some safety net sites that have attained NCQA accreditation "reported that they have become far more sophisticated as a result of the application effort and have invested in quality improvement efforts that might otherwise have gone unrealized".
Project Components:
Through the PCMH model, we propose to meet all required project components.

a) Measure NCQA PCMH readiness. Preparatory work for this project with its eventual goal of attaining national accreditation will require an assessment of current readiness status. Given the complexity of this endeavor, a detailed analysis will allow focused improvement for accreditation attainment.
b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status. After analysis of current readiness status, we will use this information to determine planning steps for focused innovation.
c) Conduct educational sessions for primary care physician practice offices, medical staff and senior leadership on the elements of PCMH, its rationale and vision As this project entails a paradigm shift in our approach to health care deliver, the education of stakeholders (medical staff, office workers and senior leadership) will be paramount to its success.
d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety□net populations (Milestones 4, 6, 8).

Unique community need identification numbers the project addresses:

- CN.10 – Improvement in asthma care
- CN.11 – improvement in vaccination rates
- CN.4 – High incidence of obesity, diabetes mellitus and heart disease
- CN.1 - Severe primary care provider shortage, wait time, expense, lack of insurance, access to care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

This project will allow us to transform the largest provider of pediatric care to economically disadvantaged children in the northern Texas Panhandle from an episodic disease-centric model to a proactive patient centered model with ability to emphasize disease prevention and health management.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT□6.1 Percent improvement over baseline of patient satisfaction scores: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains targeted for improvement utilizing the CAHPS-PCMH survey set for children.

The delivery of modern healthcare is complex, with many potential process metrics to assess quality. It is intuitive that patients will gravitate to a healthcare delivery setting that is easily accessible, timely, and of high quality. For patients to routinely access medical care in the appropriate setting by the appropriate provider, though, they must perceive the care they receive in that setting is accessible, timely, and of high quality. If we can make the patient's medical home the best perceived healthcare delivery setting, we can potentially reduce visits to less appropriate healthcare settings such as emergency departments. Individual process metrics may not accurately reflect the global perception a patient has of the healthcare they receive. Inclusion of a patient satisfaction survey tool allows us to measure and potentially improve that perception. Development of a patient centered medical home will likely improve

patient satisfaction. Access to primary care has been identified as a critical need in our region. Continued monitoring and response to patient satisfaction scores will assist in meeting that need.

Reasons/rationale for selecting the outcome measures:

Rationale/Evidence: The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on clinical care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment. We will utilize the "12-Month Survey with Patient-Centered Medical Home (PCMH) Items" tool from CAHPS.

Relationship to other Projects and Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in alearning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation: Our region used a project scoring system based on the following criteria:

Achieves Waiver Goal: Development of a patient centered medical home is directly related to Waiver goals. Federal, state, and health care providers share goals to promote more patient□centered care focused on wellness and coordinated care. PCMH development is a multi□year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost□effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over□utilization. This project will establish a foundation for transforming the primary care landscape in the Texas Panhandle by emphasizing enhanced chronic disease management through team□based care. Access to primary care was defined as a critical issue in our community this project primarily addresses Community Needs Assessment Need CN1 (severe problems with access to primary care). As 75% of our patient population is economically disadvantaged, the population affected is the population intended by the initial waiver. **SCORE 5**

Addresses Community Needs: Access to primary care has been identified as a critical need in our region (CN 1). This project specifically addresses that need by improving primary care timeliness, access, and case management. It is anticipated that it would directly improve CN 10 (improvement in asthma care) and CN 11 (improvement in vaccination rates) as well. **SCORE 5**

Project Scope/Size: This project aims to re-design one general pediatric clinic in our community. Our clinic serves as the primary care provider for more than 7000 children, the majority of whom are economically disadvantaged (75%). **SCORE 4**

Project Investment: PCMH development is a multi-year transformational effort requiring education, administrator time, and the addition of some new human resources (case management) for proper implementation. The project will require ongoing monitoring and redirection of activities based on metric and patient satisfaction results. **SCORE 4**

084563802.2.1	2.1.1	2.1.1.A-D	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards
Texas Tech Health Science Center Amarillo			084563802
Related Category 3 Outcome Measure(s):	084563802.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 RHP PP Milestone – P-3: Reorganize staff into primary care teams responsible for the coordination of patient care. Teams will be designed in such a way as to accommodate the needs of the patient population and the resources of the practice. Other clinic staff members, including billing staff, receptionists, computer technicians, and laboratory personnel, complement the primary care teams. Each of these staff members can play important roles in engendering strong trusting relationships between patients and their care team. Metric 1 [RHP PP Metric – P-3.1]: Primary Care Team a. Numerator: Number of eligible staff (LVN, RN, providers, MA, CNA, etc.) organized into care teams b. Denominator: Total number of eligible staff Baseline/Goal: Baseline: Currently 7 physicians, 3 midlevel providers, 17 residents, and 9 nurses are divided into three care clusters. Goal: All staff will be reorganized into teams to better coordinate patient care and optimize clinic efficiencies. Data Source: Documentation of	**Milestone 3** RHP PP Milestone - P–7: Track the assignment of patients to the designated care team. Metric 1 P-7.1: Tracking medical home patients Baseline/Goal: Baseline: Currently, adjustments to the patient panel and assignments to medical homes are done on an ad hoc basis based on provider availability. Goal: Systematize the assignment of patients to medical homes by reviewing provider availability and patient acuity on a monthly basis. Data Source: Submission of tracking report. Will be tracked through either the practice management system or EHR after assessment of capabilities with IT staff. Milestone 3 Estimated Incentive Payment: $451,650 **Milestone 4** [P-13]: Quality Improvement Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self□reported data and sampling that is sufficient for the	**Milestone 5** [P-7]: Track the assignment of patients to the designated care team Metric 1 [P-7.1]: Tracking medical home patients Baseline/Goal: Baseline: Currently, adjustments to the patient panel and assignments to medical homes are done on an ad hoc basis based on provider availability. Goal: Systematize the assignment of patients to medical homes by reviewing provider availability and patient acuity on a monthly basis. Data Source: Submission of tracking report. Will be tracked through either the practice management system or EHR after assessment of capabilities with IT staff. Milestone 5 Estimated Incentive Payment: $483,161 **Milestone 6** [P-13]: Quality Improvement Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self□reported data and sampling that is sufficient for the purposes of improvement.	**Milestone** 7 [P-13]: Quality Improvement Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self□reported data and sampling that is sufficient for the purposes of improvement. Metric 1 [P-13.1]: Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary Milestone 7 Estimated Incentive Payment: $466,822 **Milestone 8** [I-18]: Obtain medical home recognition by a nationally recognized agency (e.g.,NCQA, PCMH 2011). The level of medical home recognition will depend on the practice baseline and accrediting agency.

084563802.2.1	2.1.1	2.1.1.A-D	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards
Texas Tech Health Science Center Amarillo			084563802
Related Category 3 Outcome Measure(s):	084563802.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
staff assignments into care teams Milestone 1 Estimated Incentive Payment (maximum amount): $432,940 **Milestone 2** RHP PP Milestone – P-5: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment will be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self□management status, community and family need. Metric 1 (P-5.1): Determine Panel size Baseline/Goal: Baseline: Anecdotally, it is felt that currently the majority, but not all, patients are assigned to a provider. Goal: 95% of patients will be assigned to a care team based on patient complexity, provider skill set, and panel size.	purposes of improvement. Metric 1 [P-13.1]: Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary Milestone 4 Estimated Incentive Payment: $451,650	Metric 1 [P-13.1]: Number of new ideas, practices, tools, or solutions tested. Baseline/Goal: Baseline: This metric is not currently being tracked. Goal: Track this metric on a weekly basis and summarize on a quarterly basis. Data Source: Brief description of the idea, practice, tool, or solution tested each week. Quarterly summary Milestone 6 Estimated Incentive Payment: $483,160	Metric 1 [I-18.1]: Medical home recognition/accreditation a. Numerator: number of sites or clinics receiving recognition/accreditation b. Denominator: total number of sites or clinics eligible for recognition/accreditation. Baseline/Goal: Baseline= 0/0, Goal=1/1 Data Source: Documentation of recognition/accreditation from nationally recognized agency (e.g., NCQA) Milestone 9 Estimated Incentive Payment: $466,821

084563802.2.1	2.1.1	2.1.1.A-D	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards
Texas Tech Health Science Center Amarillo			084563802
Related Category 3 Outcome Measure(s):	084563802.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Panel size determination tool and EHR Milestone 2 Estimated Incentive Payment (maximum amount): $432,939			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $865,879	Year 3 Estimated Milestone Bundle Amount: $903,300	Year 4 Estimated Milestone Bundle Amount: $966,321	Year 5 Estimated Milestone Bundle Amount: $933,643
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5)**:** $3,669,142			

Project Option 2.6.4 - Other - Implement Evidence-based Health Promotion Programs
Performing Provider Name/TPI: Texas Tech University Health Sciences Center - Amarillo/084563802
Unique Project ID: 084563802.2.2

- **Provider:** Texas Tech University Health Sciences Center-Amarillo, Department of Internal Medicine (IM), is a key provider of health care for Medicaid and uninsured patients in the Texas Panhandle. IM is one of the few providers in the region that accept Medicaid patients, receive a large number of uninsured patients through the emergency room, and admit 50% of patients covered by the local program for the indigent. IM employs 18 physicians and 36 residents.
- **Intervention:** IM plans to provide smoking cessation counseling and education at the bedside of high risk hospitalized patients and offer ongoing free medication, follow-up in an attempt to help them quit smoking, and reduce future hospitalizations. The outreach will involve medical students, internal medicine residents and attendings, as well as pharmacy students, residents and attendings.
- **Need for the project:** The regional community needs assessment states that tobacco use is an important issue that needs to be addressed (CN-9, CN-10). Most recent data shows 42.9% have smoked, 32% smoke daily and 12% are still smoking "some of the time". The baseline for this project is zero as no program exists at Texas Tech to provide counsel, medication and encouragement. There is an existing DSHS Quit Smoking phone line and program but it is not routinely utilized. The Texas DSHS reports under Preventable Hospitalizations section on their site that between 2005-2010 there were the following number of hospitalizations in Potter and Randall counties that could have been prevented with better outpatient care, and specifically with smoking cessation (average hospital charge per admission is in parentheses): asthma 1,002 ($16,000-$20,000), COPD 1,705 ($20,000), HTN 513 ($15,000-$17,000) and angina 178 ($16,000). Many of these are directly related to smoking. The site states: "communities can potentially prevent hospitalizations by encouraging education on smoking cessation and minimizing shortness of breath."
- **Target population:** IM provides inpatient coverage averaging 50 patients per day (25% are uninsured), outpatient clinic follow-ups for recently discharged patients, as well as ongoing primary care patients. Of the hospitalized patients with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, stroke syndromes, hypertension and kidney disease, those who smoke are at highest risk for future complications from ongoing smoking.
- **Category 2:** The program will offer counsel and medication to approximately 20% of high risk patients admitted to IM teams in the first year, rising to 31% by the final year. Total numbers could reach 500 in the first year, up to 750 in the final year, with active recruitment reaching an estimated 2000 patients. Many of these patients will suffer readmission more quickly and frequently if they continue to smoke.
- **Category 3:** The goal is to reduce the 30-day readmission rate due to the high cost and morbidity related to each hospitalization for COPD. Even modest reductions in the readmission rate will result in significant cost savings to the health care system.

Project Option 2.6.4 - Other - Implement Evidence-based Health Promotion Programs
Performing Provider Name/TPI: Texas Tech University Health Sciences Center - Amarillo/084563802
Unique Project ID: 084563802.2.2
Project Description:

Smoking is harmful to everyone, but it is especially bad for patients with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, stroke syndromes, hypertension, and kidney disease. We plan to provide smoking cessation counseling at the bedside of hospitalized patients with these conditions and offer them ongoing free medication and follow-up smoking cessation group counseling sessions in an attempt to help them quit smoking. Many of these patients are unfunded, underfunded, or recipients of Medicaid and/or Medicare with low income status. This fact inhibits them from purchasing the necessary medications to help them quit smoking. The outreach will involve medical students, internal medicine residents and attendings, as well as pharmacy students, residents and attendings. Continuing quality improvement of this project will involve a careful annual review of the project impact to date (number of patients enrolled, number of patients attending counseling sessions, number of patients actually abstaining from smoking, number of readmissions to the hospital for smoking related illnesses, analysis of barriers to enrollment and barriers or impediments to ongoing participation by patients in the program) It may be determined that more patients can be served if counseling sessions are offered at different times or locations or perhaps at different intervals than those we have planned. Special attention will be given to whether or not the program can be extended to include more low income or unfunded participants than originally planned. These quality improvement processes are addressed in Milestones 2, 5 and 8 in the table below utilizing the guidelines of P-5. Milestone 6 (P-8) proposes the idea of semi-annual face-to-face interchange of ideas among groups with similar projects and we have suggested inclusion of groups pursuing improvement in asthma, COPD and other chronic disease management in these meetings to obtain new ideas that could help with each other's projects. This is implemented in DY 4 and 5 once the projects have had time for initial implementation and documentation of early successes and challenges. The connection to category 3 includes a proposed reduction of 30-day readmission to the hospital rate by patients with COPD who participate in this project. It is impossible to know what percentage of reduction can be achieved hence 3% is the goal initially and this will increase to a 5% reduction by the end of the project. Since each admission is known to cost the system an average of $20,000 even these modest reductions can result in real cost savings.

Project Goals:

1) Implement an innovative evidence based health promotion strategy using multi-disciplinary staff to reach targeted populations.
2) Provide education to high risk patients regarding the risk of ongoing smoking;
3) Give these patients the best care possible to help them quit smoking including ongoing counseling sessions and free medication (nicotine

patches, bupropion, or in case of failure of these varenicline (Chantix) if there is no contraindication).
4) Reduce future unnecessary exacerbations and hospitalizations of high risk patients.
5) Promote interdisciplinary teamwork between physicians, pharmacists, trainees and patients.

Challenges:

This project will need to confront the difficult challenge of convincing longstanding, hard-core smokers that it is time to quit. Recruiting research assistants and students will need to help patients overcome cultural barriers and living situations that are more conducive to smoking than quitting smoking. It will be a challenge to consistently recruit adequate numbers of faculty and students from both the School of Medicine and the School of Pharmacy to consistently offer high quality smoking cessation group sessions. It will also be a challenge to systematically record every patient encounter and the delivery of medicine both at the hospital and in the follow-up sessions.

5-Year Expected Outcome from Provider and Patients:

The expected outcomes include offering the program to increasing percentages of patients admitted to the TTUHSC internal medicine inpatient service over the five years. Initially the goal is to offer the program to at least 20% of admitted patients who smoke, the top priority being given to those patients who were specifically admitted for a smoking related complication. By the fifth year it is hoped that 31.5% of such patients will be offered this valuable program. The related Category 3 result is anticipated to be a reduction in the 30-day readmission rate for COPD which would produce an important cost savings to the health care system in our region since each of these admissions has been documented in recent years in Amarillo to cost in the range of $20,000.

Starting Point/ Baseline:

No existing project: clients = 0; trained providers so far= 0; encounters = 0; time period for baseline - 2012

Rationale:

The regional community needs assessment states that tobacco use is an important issue that needs to be addressed (CN-9, CN-10). Most recent data shows 42.9% have smoked, 32% smoke daily and 12% are still smoking "some of the time". Texas Tech does not currently have a project that addresses smoking cessation in any fashion in the Amarillo area. By providing patients counsel and medication there is the expectation of significant participation by needy patients. As mentioned above, the baseline for this project is zero as no program exists at Texas Tech. There is an existing DSHS Quit Smoking phone line and program but it is not routinely utilized by the patients and there is no face-to-face recruitment, counsel or encouragement for them as planned in this project. The Texas DSHS reports under Preventable Hospitalizations section on their site www.dshs.state.tx.us/ph that between 2005-2010 there were the following number of hospitalizations in Potter and Randall counties that could have been prevented with better outpatient care and in this case specifically with cessation of smoking: (average hospital charge per admission is in parentheses): asthma 1,002 ($16,000-20,000), COPD 1,705 ($20,000), HTN 513 ($15,000-17,000) and angina 178 ($16,000). Many of these are directly related to smoking. The site states: "communities can potentially prevent hospitalizations by encouraging education on smoking cessation and minimizing shortness of breath." Milestones and metrics chosen for this project are:

P□2,P-2.1 Development of evidence□based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community by documenting innovational strategy and plan with a computerized database of invited and participating patients.

P□3,P-3.1 Milestone: Implement, document and test an evidence□based innovative project for targeted population to include (but not limited to) the following activities:

a) Identify patients admitted to hospital reported as currently smoking

b) Offer the opportunity to learn how to quit smoking by enrolling in the Smoking Cessation Project

c) Monitor recruitment, enrollment, program participation, and success of each patient offered with direct contact and within a database

I□8,I-8.1 Increase access to health promotion programs and activities using innovative project option with an attempt to increase the percentage of target population reached. This project provides new opportunities for high risk patients to get help with smoking cessation via tested, evidence-based methods.

Project Components:

1) Implement an innovative evidence based health promotion strategy using multi-disciplinary staff to reach targeted populations
2) Provide education to high risk patients regarding the risk of ongoing smoking;
3) Provide additional and best patient care to help them quit smoking, including ongoing counseling sessions and free medication
4) Reduce future unnecessary exacerbations and hospitalizations of high risk patients

Promote interdisciplinary teamwork

Unique community need identification numbers the project addresses:

Taken from the Community Needs Assessment document, the project meets the following goals / needs.

- CN.3 Poor insurance coverage or uninsured: many of the ill patients with smoking related complications including COPD, asthma, heart disease, hypertension, stroke, etc. have no way to pay for nicotine replacement therapy or for other medication if deemed necessary. This project will provide medication free of charge and will provide free support group sessions as described above and hence address provision of quality programs to the uninsured or underinsured.
- CN.9 Tobacco use: rates of smoking in the community are quite high and are causing significant complications for patients. This need will be addressed through this project. Due to the fact that high risk patients will be enrolled selectively, the overall impact of the program will be much greater than if it was addressed to the general (smoking) public. We anticipate even higher rates of smoking among these ill, hospitalized patients who will offered help.
- CN.10 High prevalence of asthma and care issues. Due to many of the enrolled patients already having complications of their asthma or COPD due to smoking, this project specifically addresses this need in the community. Once again, there is recent, high quality evidence in the literature that a project like this can help patients quit smoking. (This is copied from above section:) A recent Cochrane Review ("Interventions for smoking cessation in hospitalized patients." Cochrane Database Syst Rev. 2012 May 16;5:CD001837.) determined after reviewing over 50 published trials that intensive smoking

cessation counseling while in the hospital followed by post-discharge contact and inclusion of nicotine replacement increased quit rates. "Fifty trials met the inclusion criteria. Intensive counseling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials). A specific benefit for post-discharge contact compared with usual care was found in a subset of trials in which all participants received a counseling intervention in the hospital and were randomly assigned to post-discharge contact or usual care. No statistically significant benefit was found for less intensive counseling interventions. Adding nicotine replacement therapy (NRT) to an intensive counseling intervention increased smoking cessation rates compared with intensive counseling alone (RR 1.54, 95% CI 1.34 to 1.79, six trials)."

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

While there is an existing DSHS Quit Smoking phone line and program but it is not routinely utilized by the patients and it is impersonal and only available over the phone after punching in all the appropriate number options on the phone tree. Patients must be highly motivated to seek help from the existing phone program and willing to work with the phone system. There is no face-to-face recruitment, counsel or encouragement for patients as is planned in this project. As described above, there is good evidence from a 2012 systematic review of published studies that an intensive program like the one we propose can effectively help patients quit smoking.

Related Category 3 Outcome Measures:

Outcome Domain 3 (Potentially Preventable Re-Admissions – 30 day)

The following outcome improvement targets were chosen to monitor the potential decrease in hospital readmissions with diagnosis of COPD and Asthma due to participation and success in a smoking cessation program.

IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Stand-alone measure)

a) Numerator: the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

b) Denominator: the number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

Reasons/rationale for selecting the outcome measures:

Please see answers under "Achieves Waiver Goal:" below in addition to the "Addresses Community Needs" section below.

Relationship to other Projects:

N/A

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:
Achieves Waiver Goal:

- This project meets the Triple Aim goal by providing a high-quality smoking cessation project based on established models in the scientific literature. This project is completely patient-centered with goal of helping patients quit smoking. This is cost effective because the investment in time and personnel will be relatively small compared to the amount of money saved by reducing harm to patient's health and therefore reduced use of health resources, specifically hospitalizations for the same smoking-related diseases.
- This project improves care coordination within the system since patients will be contacted after discharge or enrollment in the project to encourage their compliance with smoking cessation and with use of their smoking cessation medication which will be provided free of charge.
- Medicaid and uninsured patients make up a significant proportion of the patients admitted to the Texas Tech internal medicine teams at Northwest Texas Hospital hence these needy patients will be provided improved care.

A recent Cochrane Review ("Interventions for smoking cessation in hospitalized patients." Cochrane Database Syst Rev. (2012 May 16;5:CD001837.) determined after reviewing over 50 published trials that intensive smoking cessation counseling while in the hospital followed by post-discharge contact and inclusion of nicotine replacement increased quit rates. "Fifty trials met the inclusion criteria. Intensive counseling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials). A specific benefit for post-discharge contact compared with usual care was found in a subset of trials in which all participants received a counseling intervention in the hospital and were randomly assigned to post-discharge contact or usual care. No statistically significant benefit was found for less intensive counseling interventions. Adding nicotine replacement therapy (NRT) to an intensive counseling intervention increased smoking cessation rates compared with intensive counseling alone (RR 1.54, 95% CI 1.34 to 1.79, six trials)." **SCORE 5**

Addresses Community Needs: This project addresses three different community needs

CN.3 Poor insurance coverage or uninsured: many of the ill patients with smoking related complications including COPD, asthma, heart disease, hypertension, stroke, etc. have no way to pay for nicotine replacement therapy or for other medication if deemed necessary. This project will provide medication free of charge and will provide free support group sessions.

CN.9 Tobacco use: rates of smoking in the community are listed above and this need will be addressed through this project. Due to the fact that high risk patients will be enrolled selectively the overall impact of the program will be much greater than if it was addressed to the general (smoking) public.

CN.10 High prevalence of asthma and care issues. Due to many of the enrolled patients already having complications of their asthma or COPD due to smoking, this project specifically addresses this need in the community. Once again, there is recent, high quality evidence in the literature that a project like this can help patients quit smoking. (This is copied from above section:) A recent

Cochrane Review ("Interventions for smoking cessation in hospitalized patients." Cochrane Database Syst Rev. 2012 May 16;5:CD001837 determined after reviewing over 50 published trials that intensive smoking cessation counseling while in the hospital followed by post-discharge contact and inclusion of nicotine replacement increased quit rates. "Fifty trials met the inclusion criteria. Intensive counseling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials). A specific benefit for post-discharge contact compared with usual care was found in a subset of trials in which all participants received a counseling intervention in the hospital and were randomly assigned to post-discharge contact or usual care. No statistically significant benefit was found for less intensive counseling interventions. Adding nicotine replacement therapy (NRT) to an intensive counseling intervention increased smoking cessation rates compared with intensive counseling alone (RR 1.54, 95% CI 1.34 to 1.79, six trials)." **SCORE 5**

Project Scope/Size: This project is starting out with a modest goal of offering the program to approximately 20% of high risk smokers admitted to the NWTH under the TTUHSC IM teams in the first year after implementation. This number will expand each year and over the life of the project should reach at least 31.5% of high risk smoking patients from the community who are already suffering the consequences of their smoking habit. If even 5% of these participating patients can be prevented from being readmitted to the hospital due to their stopping smoking the savings will be significant. If the project proves highly successful in early years it could be expanded to include even more patients in later years. **SCORE 3**

Project Investment:

- Human resources – research technician, internal medicine residents, medical students, faculty members, pharmacy students, residents and faculty will all be required to carry out this project successfully
- Equipment purchase and maintenance – equipment will include one or two laptop computers and medication will need to be purchased for each enrolled patient. **SCORE 3**

084563802.2.2	2.6.4	N/A	OTHER – IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS
Texas Tech University School of Medicine – Amarillo			084563802
Related Category 3 Outcome Measure(s):	084563802.3.4	IT-3.9	Chronic Obstructive Pulmonary Disease 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: - P-2: Development of evidence based project for targeted population based on distilling the needs assessment and determining priority of interventions for the community. Project will be as described: recruit high risk hospitalized smokers to participate in a free program that provides free medications and free group therapy sessions to help them quit smoking. Metric(s): RHP PP Metric - P-2.1 Document in detail the design of the innovational strategy described above in the milestone to help high risk patients quit smoking. Provide evidence of the detailed plan and strategy. Baseline/Goal: [insert a data point if applicable] Baseline is 0; Goal is to illustrate the development of the strategy and plan to reach high risk smokers to help them quit. Data Source: Computerized database of admitted patients, smokers, invited and participating patients. Milestone 1 Estimated Incentive Payment:	Milestone 2: -5 Execution of evaluation process for project innovation. Metric(s): P-5.1 Document evaluative process based on input from participants and leaders of the project. P-5.1.a. This will include analysis of the number of patients enrolled, number number of patients attending counseling sessions, number of patients actually abstaining from smoking, analysis of barriers to enrollment and barriers or impediments to ongoing participation by patients in the program. P-5.1.b. Rationale/Evidence – prepare a written description of proposed changes to the program to allow more unfunded/underfunded patients to participate in the program. Strategize to remove barriers and impediments to the programs most effective implementation. Baseline is 0; Goal is to offer program to 20% of smokers admitted to TTUHSC IM services at NWTH; This number may be increased based on the evaluation number of patients attending conseling sessions, number of patients actually abstaining from smoking, analysis of barriers to enrollment and	Milestone 5: : P-5 Execution of evaluation process for project innovation. This will be repeated at least on an annual basis to determine important achievements and to strategize regarding potential changes and improvements to the program. Metric(s): P-5.1 Document evaluative process based on ongoing input from participants and leaders of the project. P-5.1.a. This will include analysis of the number of patients enrolled, number of patients attending counseling sessions, number of patients actually abstaining from smoking, analysis of barriers to enrollment and barriers or impediments to ongoing participation by patients in the program. P-5.1.b. Rationale/Evidence – prepare a written description of proposed changes to the program to allow more unfunded/underfunded patients to participate in the program. Strategize to remove barriers and impediments to the program's most effective implementation. Baseline is 0 at the beginning of each year; Goal	Milestone 8: P-5 Execution of evaluation process for project innovation. This will be repeated annually to determine important achievements and to strategize regarding potential changes and improvements to the program Metric(s): P-5.1 Document evaluative process based on ongoing input from participants and leaders of the project. P-5.1.a. This will include analysis of the number of patients enrolled, number of patients attending counseling sessions, number of patients actually abstaining from smoking, analysis of barriers to enrollment and barriers or impediments to ongoing participation by patients in the program. P-5.1.b. Rationale/Evidence – prepare a written description of proposed changes to the program to allow more unfunded/underfunded patients to participate in the program. Strategize to remove barriers and impediments to the programs most effective implementation. Baseline/Goal:

084563802.2.2	2.6.4	N/A	OTHER – IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS	
Texas Tech University School of Medicine – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.4	IT-3.9	Chronic Obstructive Pulmonary Disease 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$769,670	barriers or impediments to ongoing participation by patients in the program. P-5.1.b.Rationale/Evidence – prepare a written description of proposed changes to the program to allow more unfunded/underfunded patients to participate in the program. Strategize to remove barriers and impediments to the programs most effective implementation Baseline is 0; Goal is to offer program to 20% of smokers admitted to TTUHSC IM services at NWTH; This number may be increased based on the evaluation process. Record in prepared database the # of patients approached/offered program; Record # of patients admitted overall with smoking history. Document # of smokers approached who accept to participate in the program; Document # of medications dispersed from the hospital; Record # smoking cessation group therapy sessions held; Document # of students, research assistants and faculty participating in recruiting and f/u group meetings. Document # of meds dispensed at f/u group session meetings Baseline/Goal: [insert a data point if applicable]		is to offer program to 25% of smokers admitted to TTUHSC IM services at NWTH; This number may be increased based on the evaluation process. Record in prepared database the # of patients approached/offered program; Record # of patients admitted overall with smoking history. Document # of smokers approached who accept to participate in the program; Document # of medications dispersed from the hospital; Record # smoking cessation group therapy sessions held; Document # of students, research assistants and faculty participating in recruiting and f/u group meetings. Document # of meds dispensed at f/u group session meetings Baseline/Goal: Baseline: Original plan as described in DY3 . Goal is to document any changes or improvements made to the project during DY4. Data Source: Computerized database of admitted patients, smokers, invited and participating patients. Milestone 5 Estimated Incentive Payment: $286,318 Milestone 6:[RHP PP Milestone – P-8]	Baseline: Original plan as described in DY4 . Goal is to document any changes or improvements made to the project during DY5. Data Source: Computerized database of admitted patients, smokers, invited and participating patients. Milestone 8 Estimated Incentive Payment: $276,635 Milestone 9: [RHP PP Milestone – P-8] Participate in face-to-face meetings (via teleconferencing if not in person) twice per year with other providers to promote collaborative learning around shared or similar projects. Suggested related projects include the asthma project by Helen Farber Center 12737325.1.1 and COPD project by Golden Plains Community Hospital 197063401.1.1 to name at least two. Another possibility is the chronic disease project by Parmer County 13734330812.2.1. Metric(s): P-8.1 Participate in semi-annual face-to-face (via teleconferencing if not in person) with other providers to promote collaborative learning. c. Documentation: provide agenda, minutes, power-point

084563802.2.2	2.6.4	N/A	OTHER – IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS	
Texas Tech University School of Medicine – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.4	IT-3.9	Chronic Obstructive Pulmonary Disease 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Baseline: Original plan as described in DY2 . Goal is to document any changes or improvements made to the project during DY3. Data Source: Computerized database of admitted patients, smokers, invited and participating patients. Milestone 2 Estimated Incentive Payment: $267,645 Milestone 3:[RHP PP Milestone - P-3]: Implement, document and test an evidence based innovative project for targeted population Metric(s): P-3.1 Document implementation of a database to record patients approached to participate in the program in DY 3. Recruit interested faculty from school of medicine and pharmacy schools. Educate research assistant(s) regarding how patients will be approached and invited to participate. Calculate proposed needs and purchase medications to be used in the project. Plan schedule of meetings of participants for DY 3. Baseline/Goal: Baseline/Goal: 0 / Full description		Participate in face-to-face meetings (via teleconferencing if not in person) twice per year with other providers to promote collaborative learning around shared or similar projects. Suggested related projects include the asthma project by Helen Farber Center 12737325.1.1 and COPD project by Golden Plains Community Hospital 197063401.1.1 to name at least two. Another possibility is the chronic disease project by Parmer County 13734330812.2.1. Metric(s): P-8.1 Participate in semi-annual face-to-face (via teleconferencing if not in person) with other providers to promote collaborative learning. a. Documentation: provide agenda, minutes, power-point presentations related to the meetings. b. Rationale/evidence: Interchange of ideas between groups pursuing improved health for patients with asthma and COPD will benefit from shared experience and suggestions.	presentations related to the meetings. d. Rationale/evidence: Interchange of ideas between groups pursuing improved health for patients with asthma and COPD will benefit from shared experience and suggestions. Baseline/Goal: Documentation of any changes to the implementation based on new ideas learned from the interactive sessions of groups with similar projects in the RHP. Milestone 9 Estimated Incentive Payment: $276,635 Milestone 10 (I-8): Increase access to health promotion programs and activities using innovative project option. Improvement milestone goal is to enroll high risk smokers in an innovative, free quit-smoking program. These are typically low income patients without funds to buy medicines to help them quit smoking. The program will provide the

084563802.2.2	2.6.4	N/A	OTHER – IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS	
Texas Tech University School of Medicine – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.4	IT-3.9	Chronic Obstructive Pulmonary Disease 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	and documentation of the implementation of the innovative project to help high risk smokers quit smoking. Data Source: Custom database and logs of meetings and participants. Milestone 3 Estimated Incentive Payment: $267,644 Milestone 4 (I-8): Increase access to health promotion programs and activities using innovative project option. Improvement milestone goal is to enroll high risk smokers in an innovative, free quit-smoking program. These are typically low income patients without funds to buy medicines to help them quit smoking. The program will provide the medications free of charge which should increase access for the needy. Metric(s): [RHP I-8.1] Increase percentage of high risk smoking patients reached with the innovative project. Baseline/Goal: Baseline=0% reached; Goal is 20%		Baseline/Goal: Documentation of any changes to the implementation based on new ideas learned from the interactive sessions of groups with similar projects in the RHP. Milestone 6 Estimated Incentive Payment: $286,317 Milestone 7 (I-8): Increase access to health promotion programs and activities using innovative project option. Improvement milestone goal is to enroll high risk smokers in an innovative, free quit-smoking program. These are typically low income patients without funds to buy medicines to help them quit smoking. The program will provide the medications free of charge which should increase access for the needy. Metric(s): [RHP I-8.1] Increase percentage of high risk smoking patients reached with the innovative project. Baseline/Goal: Baseline=20% reached; Goal is 25%	medications free of charge which should increase access for the needy. Metric(s) RHP I-8.1 Increase percentage of high risk smoking patients reached with the innovative project. Baseline/Goal: Baseline=25% reached; Goal is 25% improvement to a total of 31.5% of high risk smokers admitted to the TTUHSC IM service at NWTH will be offered the free quit-smoking program including medications and opportunities to attend quit smoking support group sessions with professionals. Data Source: Custom database documenting total # of high risk smokers admitted and number of patients offered the innovative program. Milestone 10 Estimated Incentive Payment: $276,635

084563802.2.2	2.6.4	N/A	OTHER – IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS	
Texas Tech University School of Medicine – Amarillo				084563802
Related Category 3 Outcome Measure(s):	084563802.3.4	IT-3.9	Chronic Obstructive Pulmonary Disease 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	of high risk smokers admitted to the TTUHSC IM service at NWTH will be offered the free quit-smoking program including medications and opportunities to attend quit smoking support group sessions with professionals. Data Source: Custom database documenting total # of high risk smokers admitted and number of patients offered the innovative program. Milestone 4 Estimated Incentive Payment: $267,644		improvement or total of 25% of high risk smokers admitted to the TTUHSC IM service at NWTH will be offered the free quit-smoking program including medications and opportunities to attend quit smoking support group sessions with professionals. Data Source: Custom database documenting total # of high risk smokers admitted and number of patients offered the innovative program. Milestone 7 Estimated Incentive Payment: $286,317	
Year 3 Estimated Milestone Bundle Amount: $769,670	Year 3 Estimated Milestone Bundle Amount: $802,933		Year 4 Estimated Milestone Bundle Amount: $858,952	Year 5 Estimated Milestone Bundle Amount: $829,905
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $3,261,459				

Project Option: 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations.
Performing Provider: Texas Tech University Health Sciences Center – Lubbock / 084599202
Unique Project ID: 084599202.2.1

- **Provider:** The Texas Tech Physicians of Lubbock, Department of Family & Community Medicine is currently made up of twenty (20) attending/ faculty practitioners and up to thirty (30) resident positions. Combined these practitioners serve more than 30,000 patients annually. This will be a joint project between the Department of Family Medicine, Electronic Health Record Unit, and the Cardiovascular Center of Excellence
- **Intervention(s):** This project will develop and operationally embed a standardized Patient Intake Clinic that will be established to populate the Electronic Health Record (EHR). This data will then combine with other data collected in the clinical care process into the EHR and drive a Clinical Decision Support Engine (CDSE). Second, the CDSE will provide novel, real-time clinical decision support rules. These evidence-based rules will drive recommendations embedded into the provider workflow processes. Finally, for specific purposes of this project, these rules will be used to identify the population most at risk for cardiovascular disease and to proactively address population health through implementation of a gender specific, personalized-medicine, evidence-based disease prevention program.
- **Need for the project:** Greater prevention & modifiable risk identification and access to specialized care are required to optimize patient outcomes and enhance the patient experience.
- **Target population:** The family & community medicine department's current payer mix includes approximately 25% of Medicaid and approximately 14% of uninsured and under-insured patients would be considered the projects initial population. With over 15,000 patients this would amount to over 5,800 potential Medicaid/ Uninsured patients. The cardiology division of the Texas Tech Physicians of Lubbock, department of internal medicine is made up of six (6) cardiologists. From September 2011 – August 2012, the division of cardiology delivered healthcare services to approximately 9,700 patients. Of these 9,700 patients, 1,696 were Medicaid or uninsured; representing approximately 18% of the division's patient population during that time period. Many others will be positively affected by this project's interventions if the programs were to be expanded to other disease prevention areas.
- **Category 2 expected patient benefits:** Early disease detection, optimized patient outcomes, and greater patient experience.
- **Category 3 outcomes:** While not totally developed, this project's Category-3 outcomes will seek to improve on patient morbidity and mortality.

Project Option: 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations.
Performing Provider: Texas Tech University Health Sciences Center – Lubbock / 084599202
Unique Project ID: 084599202.2.1

Project Description:
Through a collaborative effort between the Texas Tech Physician's Electronic Health Record Unit, the Department of Family Medicine, and the Cardiovascular Center of Excellence, this project seeks to (1) provide a mechanism to collect and record accurate patient data that will (2) be entered into the patient's electronic health record that when combined with other clinical encounter data will (3) drive the Clinical Decision Support Engine (CDSE).

This project has three distinct phases. First, a standardized Patient Intake Clinic will be established to populate the Electronic Health Record (EHR) (Fig. 1(A)) with accurate and up to date information even before the patient enters the clinical care setting. This data will then combine with other data collected in the clinical care process into the EHR and drive a Clinical Decision Support Engine (CDSE) (Fig. 1(C)). Second, the CDSE will provide novel, real-time clinical decision support rules. These evidence-based rules will drive recommendations embedded into the provider workflow processes and will also eventually populate an actionable and near real time Physician Dashboard. For the purposes of this proposal, the rules will be used to identify the population most at risk for cardiovascular disease and to proactively address population health through implementation of a gender specific, personalized-medicine, evidence-based disease prevention program. In this third phase, the project will address prevention of heart and vascular disease but also modifying major contributory risk factors including diabetes, tobacco use, obesity, hypertension, and hyperlipidemia. Patients identified to have two contributory risk factors will be referred to the Texas Tech University Health Sciences Center Cardiovascular Center of Excellence (CCOE), Lubbock, Texas (Fig. 1(T)). Unique to this program is TTUHSC's expertise in the area of sex and gender-specific medicine and the primary modus operandi of this prevention clinic will be the development and long term implementation of a personalized prevention plan for each patient based on the most current evidence, including gender-specific recommendations as appropriate. While Cardiovascular Disease (CVD) is our focus area, this system optimization project can be readily adapted across the spectrum of clinical healthcare conditions and services.

The family & community medicine department's current payer mix includes approximately 25% of Medicaid and approximately 14% of uninsured and under-insured patients would be considered the projects initial population. With over 15,000 patients this would amount to over 5,800 potential Medicaid/ Uninsured patients.

The cardiology division of the Texas Tech Physicians of Lubbock, department of internal medicine is made up of six (6) cardiologists. From September 2011 – August 2012, the division of cardiology delivered healthcare services to approximately 9,700 patients. Of

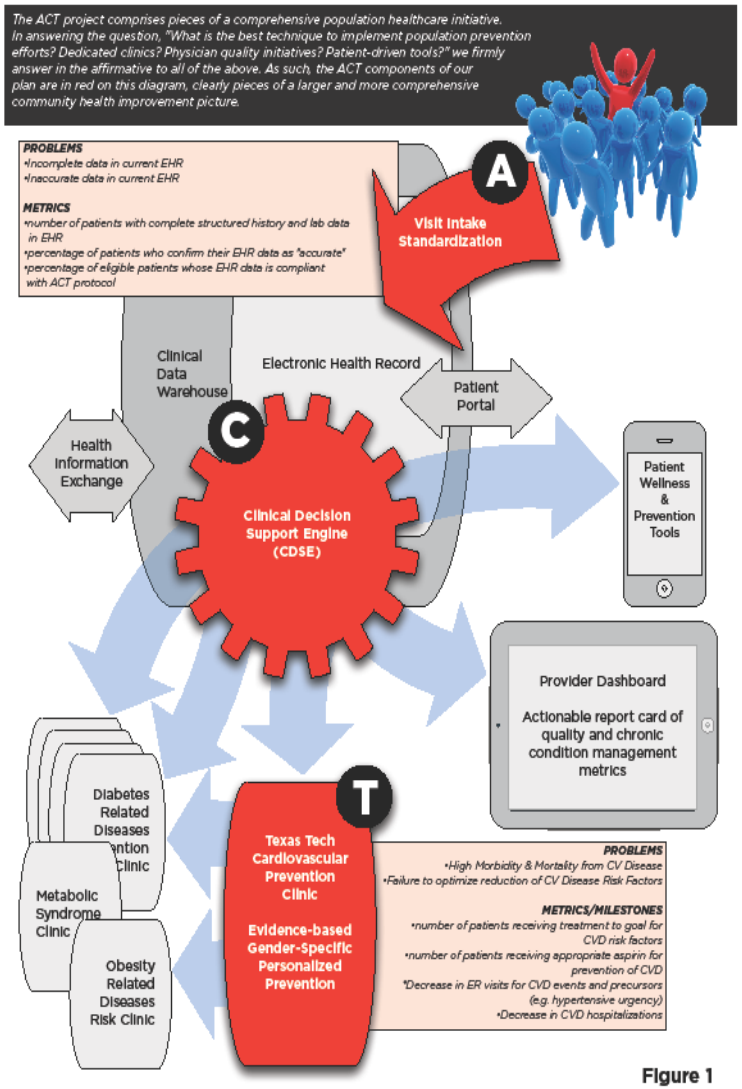

Figure 1

these 9,700 patients, 1,696 were Medicaid or uninsured; representing approximately 18% of the division's patient population during that time period. The project is designed, through the enhanced use of technology and testing for a specifically-designed patient population, to ***proactively*** intervene with patients presenting with two or more contributing risk factors for cardiovascular disease (CVD) AND for patients presenting with CVD-related events through the hospital's ED. Milestone 5 in DY3 will establish baselines by which future years (DY4 & DY5) will be measured for improvement through Milestones #8 - #10 & #12 - #14. Using the arithmetic mean of 31.75%, resulting from High Cholesterol (30.2%) and High Blood Pleasure (33.3%) for the Lubbock MSA (pop. 263,000), the number of people this project, with its cardiovascular disease focus, could initially serve would be estimated to be in excess of 83,000 people. The expansion of this integration of technology and this testing model into other risk factors associated with other infirmities; e.g. diabetes, obesity, etc., can potentially serve hundreds-of-thousands within the RHP12 region.

The primary project goal is to decrease number of patient deaths from cardiovascular disease in the population served. The secondary goal is to prevent the number of cardiovascular events and decrease subsequent ER utilization and hospitalizations in the population served. The tertiary goal is to reduce the number of modifiable risk factors through screening and treatment of patients served through application of the most recent evidence based medicine.

In the beginning, the specific effort and intent of the project will be to test the intervention model and technology's efficacy in identifying and demonstrating appropriate opportunities to modify major disease risk factors and deployment of appropriate referral mechanisms in an effort to improve health and treatment outcomes. With this in mind, we have identified our project's initial patient population as those current Texas Tech Physicians patients most at risk for cardiovascular disease. We will also use

this body of knowledge to proactively address population health through implementation of a gender specific, personalized-medicine, evidence-based disease prevention program. Once all project components demonstrate appropriate interaction, correlation, and appropriate delivery of healthcare services and advice, this model and integrated technology shall be expanded to cover other targeted disease-prevention areas including diabetes, obesity, tobacco use, prenatal care, birth spacing, and health screenings.

Comprehensive Health History has not historically been entered into the patient's EHR due to the fact that providers are challenged to enter amount of information in the time that is allotted for each primary and specialty care clinic visit. Bits and pieces are documented in physician progress notes, but the data is not query-able and actionable on an individual patient basis in order to trigger better, proactive management. Part of the challenge also revolves around a culture change that facilitates workflow processes. A standardized Patient Intake Clinic will be used to populate the EHR system to keep accurate and up to date information of patients. The Clinical Decision Support Engine will provide novel, real-time clinical decision support rules. This will drive recommendations embedded into the provider workflow processes and populate an actionable and near real time physician dashboard. We will also address prevention of heart and vascular disease while modifying major contributory risk factors such as diabetes, tobacco use, obesity, hypertension, and hyperlipidemia.
Due to having three (3) distinct phases with this project and focusing the project on cardiovascular disease (CVD) risk factors, P-X and I-X milestones were used in an effort to more-specifically establish baselines and demonstrate very specific risk factor reductions and improvements.

5-year Expected Outcome:

- Decrease mortality and morbidity due to heart disease and stroke
- Decrease the number of hospitalizations due to heart disease, stroke and uncontrolled hypertension
- Measure improvements in the conditions associated with increased risk for heart disease and stroke
- Decrease utilization of hospital emergency department services due to acute CVD events
- Achieve a robust heart disease and stroke prevention clinic, the CVCOE Cardiovascular Prevention Clinic, servicing thousands of at-risk patients annually.

The "ACT" project will serve to fulfill the following community needs:

1. *CN.4 – High incidence of obesity, diabetes mellitus, and heart disease*
2. *CN.5 – Need for specialist to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, & chronic lung disease*
3. *CN.6 - Need for screenings including cancer, mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal examinations*

4. *CN.7 – Insufficient maternal and prenatal care, especially for first trimester teen pregnancy, high percentage of unmarried mothers*

Starting Point/Baseline: Less than 10% of patients treated in our organization currently have comprehensive Health History and associative components entered into the EHR.

Currently, an EHR Clinical Decision Support Engine exists only in a very rudimentary form and will need to be grown into the robust tool envisioned. Performance improvement monitoring is currently retrospective and limited. Developing and implementing the proposed tool will enable real-time action and include 100% of the provider's patient population being served.

In Lubbock County MSA, home to TTUHSC CVCOE in Cardiology:

Population (est.): 263,000

Disease Risk Factor Prevalence:

1. Overweight (BMI 25 or greater) 71.7%
2. Heart Disease 26.6%
3. Obesity (BMI 30 or greater) 38.7%
4. Stroke 1%
5. No Leisure Time Physical Activity 23.3%
6. High Blood Pressure 33.3%
7. Current Smoker 18.8%
8. High Cholesterol 30.2%
9. Diabetes 11.6%
10. Intake of Fruit & Vegetables is <5 times/ day 77.6%

Hospital discharge data of cost due to heart disease and stroke:

1. Ischemic Heart Disease $65,995,843
2. Hemorrhagic Stroke $5,006,246
3. Ischemic Stroke $14,807,810

Rationale: The goal is to populate and implement an EHR Clinical Decision Support Engine to enable providers to proactively and efficiently target the prevention of cardiovascular disease and address major contributory risk factors including diabetes, tobacco use, obesity, hypertension, and hyperlipidemia. Quality patient health history information populated into the Clinical Decision Support Engine will trigger provider decision support rules to fire identifying patients having two or more cardiovascular risk factors needing referral to the CCOE in order to prevent adverse consequences and/ or avoidable hospital admissions.

Heart disease has been targeted since the National Heart Lung and Blood Institute's Heart Truth campaign launched in 2001 placed, heart disease in women, in the national spotlight. Many would agree it was cardiovascular disease that started the

discussion of gender differences in health on a global scale. Cardiovascular disease (CVD), including heart disease and stroke, is the leading cause of death for women in the USA. Compared to men, women have higher CVD mortality, higher morbidity following a heart attack or stroke, lower awareness of CVD, and a higher prevalence of most major risk factors for CVD. They are also more likely to have different symptoms when having a heart attack. Since 1984, in the USA, the number of CVD deaths for females has exceeded those for males.

Yet heart disease and stroke do not discriminate. Cardiovascular disease (CVD) causes one in three (approximately 800,000) deaths reported in the USA each year. It causes 1/3 of the deaths annually in Texas. Nationally, annual direct and overall costs resulting from CVD are estimated at $273 billion and $444 billion, respectively. The cost to Texas is estimated at $8 billion. Heart disease and stroke disproportionately impact those with lower levels of income and education. The prevalence of heart disease is almost twice that for those with an annual salary of $25,000 (9.7%) as compared with those whose annual income is >$50,000 (4.3%) and for those with no high school diploma (10.7%) versus those with some college (6.4%). The same holds true for stroke. Strategies that address common heart disease and stroke risk factors, especially in this high-risk population, can greatly reduce the burden of disease. An examination of the trends in modifiable risk factors in Texas over the past 12 years demonstrates an increase in the prevalence of high cholesterol, obesity, diabetes, and high blood pressure. (Source: BRFSS Health Statistics Summary 2007).

There are heart disease risk factors which cannot be changed such as age, gender, and family history. However, most of the major risk factors are modifiable; meaning they can be improved through lifestyle changes, early detection, and treatment. These modifiable risk factors include e obesity, lack of exercise, smoking, high blood pressure, diabetes, and high cholesterol. In addition to these known risk factors, a well-known preventative therapy, aspirin, is underutilized or used inappropriately in men and women. Through this health promotion and prevention project, we will expand the number of patients receiving appropriate screening, diagnosis, and treatment of the major modifiable (cardiovascular) risk factors in addition to improving the number of those receiving appropriate aspirin therapy for primary prevention of CVD.

TTUHSC will achieve these goals through the establishment of a personalized-medicine (cardiovascular) prevention program that will improve clinician compliance in evidence-based clinical protocols. The targeted cardiovascular disease prevention program will be embedded throughout the Primary Care Clinics. The heart disease specific prevention program will be housed within the TTUHSC CVCOE. Adult patients with two or more major cardiovascular risk factors will be identified from our electronic medical record and a system recommendation will be sent to the primary provider to refer the patient to the cardiovascular disease prevention program. This program will utilize prevention strategies in the “2008 Texas Plan to Reduce Cardiovascular Disease” and the “2011 US Department Health and Human Services Million Heart Program”, a program launched in 2011 with the goal to reduce the number of heart attacks and strokes by 1,000,000 over the next 5 years. The opportunity for dramatic decreases in mortality and morbidity resulting in lower treatment expenditures can be achieved with a successful prevention program. Disease management emphasizes prevention of disease and disease-related exacerbations and complications using evidence-based guidelines and patient

empowerment tools. Efficient, consistent collection of quality health status/history data populating a novel Clinical Decision Support Engine will engage physicians to proactively act to manage and improve the health status of the patient population served. By concentrating on the causes of cardiovascular disease, the community moves from a focus on sickness and disease to one based on wellness and prevention. This project makes available quality comprehensive health history including family history, procedures, and current medications entered into the EHR to trigger real time decision support and performance improvement feedback to ultimately achieve provider interventions to improve population health.

- The ACT project will function as a patient registry system to enhance the provision of patient follow-up, screenings for related risk factors, and track status of outcomes.
- The ACT project will include embedded clinical evidence-based practice guidelines to support improved outcomes.
- The ACT project will include decision support to prompt reminders of care and real-time status of clinical performance measures
- The ACT project will establish evidence-based disease prevention programs for targeted populations to reduce their risk of morbidity and mortality. The first of these will be the Texas Tech Cardiovascular Prevention Clinic.

While there are no specific project core components, the program will include Process Milestone P-7 (Milestones #4, #7, & #9) as our continuous quality improvement (CQI) component in DY3, DY4, & DY5 respectively in order to promote continuous learning and exchange between providers and decide collectively how to continue improving performance of the program across all patients and providers impacted by the program.

This disease prevention program option was chosen as a direct intervention to concentrate and emphasize prevention of disease-related exacerbations with the use of improved technologies, enhanced patient information, and evidence-based guidelines, in an effort to move from a focus on sickness and disease to one based on wellness and prevention.

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: N/A

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and in the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	This project addresses all of the waiver goals. It assures patients will receive a higher quality, more patient-centered care in the most efficient ways. While it does not specifically focus on the care provided to Medicaid and the uninsured, each of these patient populations will benefit from the efforts of the program. This project will add positively to further develop and maintenance of a coordinated care delivery system and through this programs effort, patients will be more likely to receive the type of care that will prevent needless emergency department encounters and hospitalizations.	**4**
Addresses Community Need(s)	This project will directly impact community needs *CH.4 – high incidence of obesity, diabetes, and heart disease; CN.5 – Need for specialist to assist in the treatment of diabetes, obesity, heart disease, asthma, chronic lung disease;* and as a model, could be expanded to include other disease specific issues and conditions.	**4**
Project Scope/Size	This program will produce increased access to specialist at a preventive juncture that will head off expensive encounters to emergency rooms and needless hospitalization admissions – thereby, creating savings to the region's healthcare system. As a result of the inherent, built-in "early warning" nature of this project, patient outcomes will be better and a more comprehensive, integrated system of patient care can be discovered and realized. This program has the capacity to impact a lot of patient lives; now from a cardiovascular disease management perspective to in the future, broader applications in other disease conditions.	**4**
Project Investment	This project will require a rather significant investment into the design and building-out of the Patient Intake Clinic module as well as significantly increasing the capabilities associated with the clinical decision support engine. Done correctly, significant time will be needed to complete the IT engineering, provider training, and development and implementation of risk protocols.	**4**

Unique Identifier: ***084599202.2.1***	***RHP PP Reference number PP – 2.7.1***	***Project Component(s):*** ***PP - N/A***	***Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.4*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Development of innovative data collection and data assimilation processes, sex and gender specific clinical protocols for heart disease risk factor screening, diagnosis and treatment-to-goal that positively transforms, and implementation of a CDSE. <u>Metric 1 [P-1.1]:</u> Document innovational project's strategy, protocols and plan. Goal: To develop and test a new model of healthcare delivery and disease management Data Source: Performing Provider evidence and presentation of innovational plan Milestone 1 [P-1] Estimated Incentive Payment *(maximum amount):* $484,607 **Milestone 2 [P-2]:** Implement sex and gender specific clinical protocols for heart disease risk factor screening, diagnosis and treatment-to-goal (as applicable) in	**Milestone 3 [P-4]:** Development and execution of an evaluative process for the innovative "ACT" project <u>Metric 1 [P-4.1]:</u> Present, through the performing provider's documentation, evidence of an evaluation process, and the execution thereof, that demonstrates a review of the evaluation's resulting process, tools and analytics. Goal: To provide for continuous improvements to the program Data Source: Performing Provider documentation of development & implementation of an evaluative process. Milestone 3 [P-4] Estimated Incentive Payment *(maximum amount):* $252,776 **Milestone 4 [P-7]:** Participate in face-to-face learning through meetings and training sessions at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar		**Milestone 7** [P-7]: Participate in face-to-face learning through meetings and training sessions at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars with other providers within the region. Goal: To promote continuous learning and exchange between providers and to decide collectively how to "raise the floor" for performance across all providers. Data Source: Documentation of semiannual meetings including meeting agendas, & slides from presentations, and/or meeting notes. <u>Metric 2 [P-7.2]:</u> Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: To invest in the learning and sharing of ideas	**Milestone 11** [P-7]: Participate in face-to-face learning through meetings and training sessions at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars with other providers within the region. Goal: To promote continuous learning and exchange between providers and to decide collectively how to "raise the floor" for performance across all providers. Data Source: Documentation of semiannual meetings including meeting agendas, & slides from presentations, and/or meeting notes. Metric 2 [P-7.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: To invest in the learning and sharing of ideas

UNIQUE IDENTIFIER: ***084599202.2.1***	***RHP PP REFERENCE NUMBER PP – 2.7.1***	***PROJECT COMPONENT(S): PP - N/A***	***Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.4*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
the target population to reduce cardiovascular deaths, events, and associated modifiable risk factors Metric 1 [P-2.1]: Through the EHR-generated information on BMI, lab values, and problem list, the project will track the structured intake and the population of the CDSE that will lay the foundation for appropriate referrals to the CCOE. Goal: To develop and test a new model of healthcare delivery and disease management Data Source: Documentation of the project's implementation strategy and testing outcomes Milestone 2 [P-2] Estimated Incentive Payment *(maximum amount):* $484,607	projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars with other providers within the region. Goal: To promote continuous learning and exchange between providers and to decide collectively how to "raise the floor" for performance across all providers. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-7.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: To invest in the learning and sharing of ideas Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented		Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 [P-7] Estimated Incentive Payment (maximum amount): $270,413 **Milestone 8 [I-X]:** Using a baseline of zero percentage (0%), identify impact on target intervention by demonstrating increased compliance with national guidelines in the screening, diagnosis, and treatment-to-goal of hypertension (JNCVII), hyperlipidemia (National Cholesterol Education Program Adult Treatment Panel-III), diabetes (National Diabetes Association), and aspirin for primary prevention of heart disease (American Heart Association 2011 Guidelines for the Prevention of Cardiovascular Disease in Women)	Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 11 [P-7] Estimated Incentive Payment (maximum amount): $261,267 **Milestone 12 [I-X]:** Using a baseline of zero percentage (0%), identify impact on target intervention by demonstrating increased compliance with national guidelines in the screening, diagnosis, and treatment-to-goal of hypertension (JNCVII), hyperlipidemia (National Cholesterol Education Program Adult Treatment Panel-III), diabetes (National Diabetes Association), and aspirin for primary prevention of heart disease (American Heart Association 2011 Guidelines for the Prevention of Cardiovascular Disease in Women)

UNIQUE IDENTIFIER: 084599202.2.1	RHP PP REFERENCE NUMBER PP – 2.7.1	PROJECT COMPONENT(S): PP - N/A	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				TPI: 084599202
Related Category 3 Outcome Measure(s): TBD	084599202.3.4	Reference number(s) from RHP PP: TBD	Outcome Measure (Improvement Target) Title(s): TBD	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	the "raise the floor" improvement initiative after the semiannual meeting. Milestone 4 [P-7] Estimated Incentive Payment *(maximum amount):* $252,775 **Milestone 5 [P-X]:** Establish baseline of hospital ED utilization statistics and analytics related specifically to acute CVD events. This customized process milestone is necessary to test the efficacy of the "ACT" intervention - as a concept - , and to tailor our concept/ model to local context, in reducing the utilization and associative cost of healthcare delivered through the use of hospital ED services related with acute CVD events. Metric 1 [P-X.1]: The project will establish the current demonstration year's number of CVCOE-referred patients that utilized hospital ED services during this DY3 resulting specifically from an acute CVD event and will serve as a baseline for future		Metric 1 [I-X.1]: To test for better health and improved care, the "ACT" initiative will demonstrate, that targeted intervention will result in a minimum of 25% of program participants that will be in compliance with national guidelines in the following parameters: (1) Screening, (2) Diagnosis, and (3) Treatment-to-goal as measured by (1-Number of referrals that presented for more comprehensive screening exam at CVCOE Clinic divided by the Number of referrals generated to the CVCOE Clinic); (2-Number of referrals that complied with further testing to facilitate diagnosis divided by Number of referrals that presented to the CVCOE Clinic for diagnosis); and the (3-Number of referred patient that achieved treatment-to-goal divided by the Number of referred patients that presented to the CVCOE Clinic for three or more visits) Goal: Increased patient compliance of 25% improvement from baseline with national guidelines Data Source: Provider-prepared	Metric 1 [I-X.1]: To test for better health and improved care, the "ACT" initiative will demonstrate, that targeted intervention will result in a minimum of 50% of program participants that will be in compliance with national guidelines in the following parameters: (1) Screening, (2) Diagnosis, and (3) Treatment-to-goal as measured by (1-Number of referrals that presented for more comprehensive screening exam at CVCOE Clinic divided by the Number of referrals generated to the CVCOE Clinic); (2-Number of referrals that complied with further testing to facilitate diagnosis divided by Number of referrals that presented to the CVCOE Clinic for diagnosis); and the (3-Number of referred patient that achieved treatment-to-goal divided by the Number of referred patients that presented to the CVCOE Clinic for three or more visits) Goal: Increased patient compliance of 50% improvement from baseline with national guidelines Data Source: Provider-prepared

UNIQUE IDENTIFIER: ***084599202.2.1***	***RHP PP REFERENCE NUMBER PP – 2.7.1***	***PROJECT COMPONENT(S): PP - N/A***	***Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.4*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	demonstration year improvement milestone comparisons. [CVCOE-referred patients that utilized hospital ED services resulting from an acute CVD event divided by family medicine control group consisting of patients with similar CVD risk that utilized hospital ED services resulting from an acute CVD event] Goal: To establish a baseline of CVCOE-referred patients that utilized hospital ED services during this DY3 resulting specifically from an acute CVD event Data Source: Annual summary analysis of CVCOE and hospital ED records Milestone 5 [P-X] Estimated Incentive Payment *(maximum amount):* $252,775 **Milestone 6 [I-5]:** Identify the percent of patients in defined population who currently have comprehensive and accurate health history data and health maintenance data entered into their EHR conducive to populating an EHR-statistics and analysis Milestone 8 [I-X] Estimated Incentive Payment *(maximum amount):* $270,410 **Milestone 9 [I-7]:** Increase access to disease prevention program by increasing patient referrals to the CVCOE Cardiovascular Prevention Clinic through the use of EHR notification for patients with 2 or more major modifiable risk factors. Metric 1 [I-7.1]: Demonstrate a 25% referral rate of the target population, for those that qualify as referrals from the intervention of the "ACT" program, to the CVCOE Cardiovascular Prevention Clinic. (Number of patients served in the Texas Tech Physicians Department of Family Medicine with two or more CVD risk factors referred to the CVCOE Cardiovascular Prevention Clinic divided by the Total number of individuals of patients served in the Primary Care departments with two or more CVD risk factors)	statistics and analysis Milestone 12 [I-X] Estimated Incentive Payment *(maximum amount):* $261,266 **Milestone 13 [I-7]:** Increase access to disease prevention program by increasing patient referrals to the CVCOE Cardiovascular Prevention Clinic through the use of EHR notification for patients with 2 or more major modifiable risk factors. Metric 1 [I-7.1]: Demonstrate a 35% referral rate of the target population, for those that qualify as referrals from the intervention of the "ACT" program, to the CVCOE Cardiovascular Prevention Clinic. (Number of patients served in the Texas Tech Physicians Department of Family Medicine with two or more CVD risk factors referred to the CVCOE Cardiovascular Prevention Clinic divided by the Total number of individuals of patients served in the Primary Care departments with two or more CVD risk factors)

UNIQUE IDENTIFIER: 084599202.2.1	RHP PP REFERENCE NUMBER PP – 2.7.1	PROJECT COMPONENT(S): PP - N/A	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				TPI: 084599202
Related Category 3 Outcome Measure(s): TBD	084599202.3.4	Reference number(s) from RHP PP: TBD	Outcome Measure (Improvement Target) Title(s): TBD	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	generated CDSE. Metric 1 [I-5.1]: Identify the number of patients who, by the end of DY3, have comprehensive health history data and health maintenance data entered into their EHR conducive to populating an EHR-generated CDSE that generates data and patient information to providers in a novel, user-friendly workflow-embedded format, consistent with evidence-based medicine. [# of individuals of target population demonstrating accurate and comprehensive health history and health maintenance data in their respective EHR divided by the number of individuals in the target population] Goal: Develop a baseline Data Source: EHR-generated documentation of target population reached, as designated in the project plan Milestone 6 [I-5] Estimated Incentive Payment *(maximum amount):* $252,775		Goal: To increase appropriate referral rate to the CVCOE; thus proving efficacy of the program. Data Source: Weekly, real-time EHR data query (summarized quarterly) Milestone 9 [I-7] Estimated Incentive Payment *(maximum amount):* $270,410 **Milestone 10 [I-X]:** Demonstrate a decrease in hospital ED utilization associated with acute CVD events, as compared to the baseline established in DY3; P-X. This customized improvement milestone is necessary to test the efficacy of the "ACT" intervention - as a concept - , and to tailor our concept/ model to local context, in reducing the utilization and associative cost of healthcare delivered through the use of hospital ED services related with acute CVD events. Metric 1 [I-X.1]: The project will demonstrate a ≥5% decrease in the baseline established in DY3; P-X. [CVCOE-referred patients that	Goal: To increase appropriate referral rate to the CVCOE; thus proving efficacy of the program. Data Source: Weekly, real-time EHR data query (summarized quarterly) Milestone 13 [I-7] Estimated Incentive Payment *(maximum amount):* $261,266 **Milestone 14 [I-X]:** Demonstrate a decrease in hospital ED utilization associated with acute CVD events, as compared to the baseline established in DY3; P-X. This customized improvement milestone is necessary to test the efficacy of the "ACT" intervention - as a concept - , and to tailor our concept/ model to local context, in reducing the utilization and associative cost of healthcare delivered through the use of hospital ED services related with acute CVD events. Metric 1 [I-X.1]: The project will demonstrate a ≥10% decrease in the baseline established in DY3; P-X. [CVCOE-referred patients that

Unique Identifier: ***084599202.2.1***	***RHP PP Reference Number PP – 2.7.1***	***Project Component(s):*** ***PP - N/A***	***Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*TPI: 084599202*
Related Category 3 Outcome Measure(s): *TBD*	*084599202.3.4*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			utilized hospital ED services resulting from an acute CVD event divided by family medicine department control group consisting of patients with similar CVD risk that utilized hospital ED services resulting from an acute CVD event] Goal: To decrease utilization of hospital ED events due to acute CVD events. Data Source: Annual summary analysis of CVCOE and hospital ED records Milestone 10 [I-X] Estimated Incentive Payment *(maximum amount):* $270,410	utilized hospital ED services resulting from an acute CVD event divided by family medicine department control group consisting of patients with similar CVD risk that utilized hospital ED services resulting from an acute CVD event] Goal: To decrease utilization of hospital ED events due to acute CVD events. Data Source: Annual summary analysis of CVCOE and hospital ED records Milestone 14 [I-X] Estimated Incentive Payment *(maximum amount):* $261,266
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $969,214	Year 3 Estimated Milestone Bundle Amount: 1,011,101		Year 4 Estimated Milestone Bundle Amount: $1,081,643	Year 5 Estimated Milestone Bundle Amount: $1,045,065
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,107,023				

Project Option: 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.
Unique Project ID: 084599202.2.2
Performing Provider: Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)

- **Provider:** The Texas Tech Physicians of Lubbock, Department of Internal Medicine is currently made up of thirty-four (34) attending/ faculty practitioners and up to thirty-nine (39) resident and eighteen (18) fellow positions. Combined, these practitioners see more than 38,500 clinic visits and over 90,000 inpatient and outpatient visits annually. This department of the TTUHSC School of Medicine is a significant provider of cardiovascular disease, endocrinology, general internal medicine, geriatrics/ palliative care, infectious diseases, nephrology, oncology/ hematology, and pulmonary & critical care services.

- **Intervention(s):** The DY2 and DY3 milestones are focused on the identification of the patient base to be targeted, development of a patient navigation training program, and the marketing to and recruitment of targeted patients. In DY4 and DY5 the focus of the interventions will shift from policy and operational logistic to the demonstration of improved clinical outcomes, increased compliance with medication regimens, and the promotion of continuous improvement opportunities along with the identification and implementation of patient care and support "best practices."

- **Need for the project:** The need for this project in RHP12 is immense as the geriatric population is the fastest growing and is one of the most vulnerable among patient populations in general. Many in this group may also suffer some of the greatest disparities in access to care and "age-sensitive" care.

- **Target population:** While the total exact numbers of Medicaid and uninsured patients is unknown, the department's payer mix includes ~ 13% Medicaid and approximately, 10% of uninsured and underinsured, and serves a large Medicare base. For the period September 1, 2011 through August 31, 2012, Texas Tech Physicians of Lubbock served in excess of 4,760 hospital inpatient patients age 65 or older. This represents, for the same time period, over 5,950 inpatient encounters. Based on the same reporting methodology and reporting time period, 569 patients, or approximately 12% of the above patients age 65 or older were dual eligible for Medicare and Medicaid. Should 12% be a good representation of those in the region dually-

eligible for both Medicare and Medicaid, this project, through expansion in other parts of RHP12, has the potential of impacting over 6,100 Medicare/ Medicaid dually-eligible seniors within RHP12 alone.

- **Category 2 expected patient benefits:** The project seeks for improved patient outcomes, and activities of daily living.

- **Category 3 outcomes:** The outcomes of this project will seek to reduce the use of hospital emergency rooms by this targeted population for re-entry into the healthcare delivery system and demonstrate a reduction in potentially preventable hospital readmissions due to better direction and assurance of care in the community-based environment.

Project Option: 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.
Performing Provider: Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)/084599202
Unique Project ID: 084599202.2.2

Project Description:
The purpose of this project is to provide navigation services to elderly West Texas residents who have two or more chronic conditions and are at high risk of disconnect from institutionalized health care.

The population group aged 65 and older suffer from multiple healthcare issues at rates far greater than the young and young adult, including heart disease, diabetes, osteoarthritis, cerebrovascular disease, pulmonary disease, and Alzheimer's Disease and other dementias. Many in this group may also suffer some of the greatest disparities in access to care and "age-sensitive" care. This is only compounded in the rural areas of West Texas, which have some of the lowest physician per population ratios in the State. This program will serve to provide: (1) evidence-based, patient-centered and age-sensitive care for older West Texans utilizing an inter-professional care model to include medicine, nursing, pharmacy, social work, nutrition and community health workers; (2) transition-of-care services upon hospital or emergency room discharge to ensure continuity of care and to maximize community resources to prevent readmissions and/or institutional care and promote quality of life as appropriate for each individual; and (3) screenings for and management of dementia and delirium, whose debilitating effects magnify the catastrophic results of other medical conditions of older adults. The project will be undertaken as an initiative of the Regional Health Partnership – Region 12 (RHP-12). The RHP-12 is centered in West Texas and the Texas Panhandle with three urban counties and 44 rural counties with a total population in 2010 of approximately 891,000. The rural population is approximately 42% of this total and the population over aged 65 is approximately 10% of the total.

The Patient Care Navigation Program will help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations, and other components of the health care system. Through the use of Patient Navigators who will work with physicians, pharmacists, nurses, and community health workers to:

- Facilitate compassionate, sensitive, and culturally–attuned communication among patients, family members, survivors, and healthcare providers.
- Ensure the patient is directed to the most appropriate level of care to maximize functional abilities and quality of life and avoid readmissions to acute care settings

- Coordinate care among providers, including, but not limited to, primary care, medical specialist, allied health, and pharmacy professionals.
- Coordination of transportation needs as needed.
- Ensure appropriate medical records are available at medical appointments.
- Facilitating post-hospitalization follow-up appointments.
- Provide necessary community supports to allow patients to be cared for in their homes for as long as possible including visits by community health workers.
- Reduce hospitalizations and emergency room visits for the target population.

For the population who are considered to be at the age of retirement or older – 65 years and older, the total number of persons in Texas was 2,601,886 or 10.3% of the total population in 2010. This region had a total of 50,863 or 13.7% in this older age group. In the same age group of 65 years and over, males in Texas represented 1,135,664 or 4.5% of the total population and females totaled to 1,466,222 or 5.8%, while in this RHP-12 Rural study area, males totaled to 22,561 or 6.1% of all persons in this area and females represented 28,302 or 7.6% of all persons in this area. For the period September 1, 2011 through August 31, 2012, Texas Tech Physicians of Lubbock served in excess of 4,760 hospital inpatient patients age 65 or older. This represents, for the same time period, over 5,950 inpatient encounters. Based on the same reporting methodology and reporting time period, 569 patients, or approximately 12% of the above patients age 65 or older were dual eligible for Medicare and Medicaid. Should 12% be a good representation of those in the region dually-eligible for both Medicare and Medicaid, this project, through expansion in other parts of RHP12, has the potential of impacting over 6,100 Medicare/ Medicaid dually-eligible seniors within RHP12 alone. As part of the Regional Health Partnership – Region 12 (RHP-12) initiative, this project will address the three objectives identified by the Institute of Healthcare Improvement as key to improving the nation's healthcare system. These three objectives, known as *The Triple Aim*, are to improve the health of a defined population, enhance the patient care experience through improved quality and access, and reduce the cost of care.

5-year Expected Outcome:

1. Improved interdisciplinary coordination of care for the multiple medical problems experienced by the patient population, and increased inter-professional team and staff satisfaction with the care of this targeted population.
2. Improved clinical outcomes including a reduction in exacerbations of chronic illnesses, hospitalizations, and emergency room visits.
3. Reduced heath care cost resulting from more site-appropriate delivery of care, reduced hospitalizations and reduced emergency room visits.

4. Reduced adverse effects of medications resulting from more appropriate detection and therapeutics.
5. Provide screening, management, and patient and family education for cognitive impairment and AD, the under detection and lack of attention to which significantly negatively impacts all other health domains of both the patient and his/ her family and others.

The educational component of this clinical program will increase sensitivity, understanding and ability to care for older adults among the next generation of health care professionals currently in the participating training programs of Texas Tech University Health Sciences Center (TTUHSC) which include the schools of medicine, nursing, allied health, and pharmacy. This program will use every opportunity to address the imperative of increasing skills in interdisciplinary team care for health professional students and residents, consistent with the Institute of Medicine mandate. With the persistent dearth of geriatricians and gerontologist, increasing the capacity of health care providers in other disciplines to provide friendly-care specific to this target population is critical.

Starting Point/Baseline:

Baseline date will include the following:

- Demographic of over 25,000 persons aged 65 and over in the Lubbock MSA and the University Medical Center hospital catchment area exceeding 100,000 aged 65 and over
- Hospital discharge data targeting patients aged 65 and over with two or more chronic illnesses and with two or more hospitalizations in the last 12 months (DY2: Milestone 4 [I-X])
- Emergency room discharge data targeting patients aged 65 and over with two or more chronic illnesses with three or more emergency visits in the past 6 months (DY2: Milestone 4 [I-X])

Rationale: It is known that as AD progresses, cost increase, and by identifying persons with AD and other forms of cognitive impairment, and effecting holistic out-of-hospital care strategies, that cost savings can be realized, even more so in the later stages of the disease. This disparity deficit only worsens for minority, poor, or other disenfranchised at-risk elders of the community, who otherwise lack access to proactive or preventative care communications and resultant outpatient interventions which may obviate the need for an emergency room admission or hospitalization. AD and other cognitive impairments only make cardiac, pulmonary, diabetic, or renal problems worse. Whereas it appears that the older adult may be suffering from heart disease, emphysema, or chronic infections, in actuality it is the dementia rendering the older adult unable to cope with his or her medical illnesses and care needs which result in increased emergency department visits, hospitalizations, cost, and utilization of care. The primary illness is AD: the manifestation of this underdiagnosed disease is the chronic medical conditions which should be getting better with

standard-of-care medical management, yet bare not. The complexity of care with older adults with two or more chronic illnesses cannot be handled by the typical primary care office or clinic. Systems of care such as a Patient Care Navigation Program are required to address the complex needs of this patient population to ensure communication and collaboration across multiple healthcare teams and systems and promote the best possible outcomes for the patient and lower costs to the healthcare system.

As part of the Regional Health Partnership – Region 12 (RHP-12) initiative, this project will address the three objectives identified by the Institute of Healthcare Improvement as key to improving the nation's healthcare system. These three objectives, known as *The Triple Aim*, are to improve the health of a defined population, enhance the patient care experience through improved quality and access, and reduce the cost of care. To address these three *Triple Aim* objectives, health care for older adults should focus on three areas *(RHP12 Community Needs)*: 1) primary prevention and treatment of those acute illnesses for which immunizations and preventative measures exist *(CN.11 – Inadequate vaccination of the population)*; 2) management and secondary prevention of chronic diseases causing morbidity and hastening mortality *(CN.5 – Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, and chronic lung)*; and 3) screening for those diseases nearly uniformly limited to the elderly such as dementia, frailty, and fall syndromes *(CN.2 – Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial access/ contact)*. It is estimated that over a third of a million Texans already suffer from Alzheimer's disease (AD), with over 30,000 new cases yearly. Approximately 3 – 5% of all Texans at age 65 years have AD, with that percentage doubling every five years of life thereafter. This results in more than one death for every twenty Texans annually, with our State ranking second nationally in AD deaths and third in total number of AD cases. This creates an economic burden of nearly $15 billion annually to the State, with over $7 billion in lost productivity to businesses and another $17 billion in unpaid care by the over one million caregivers of AD statewide. These statistical and financial conclusions are only compounded in rural areas of West Texas, where our program will endeavor to increase access to, and age-sensitive care for the older adults, with screening and management of these diseases unique to our elders *(CN.1 – Severe primary care provider shortage, wait time, expense, lack of insurance, access to care and CN.6 – Need for cancer screenings with mammography, pap smears, colonoscopies, sigmoidoscopy, rectal exams)*.

Required core project components:

- 2.9.1(a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

The Patient Navigation program will develop processes and protocols that will be administered through program leadership and program-trained/ graduated Patient Navigators. As indicated in Milestone #4, the program's processes and protocols will establish baselines that will focus on, and identify frequent ED users and hospital readmissions within the elderly patient population, and,

- 2.9.1(b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

As indicated by Milestone #2, the program will develop a program used to train health care professionals as Patient Navigators.

- 2.9.1(c) Connect patients to primary and preventive care.

The program will deploy these newly-trained Patient Navigators to reach out to those frequent ED/ Hospital-users as an intervention to redirect these selected representatives of the target population into the program; through which these program participants can be re-directed to more appropriate care delivery sites – including connecting patients to primary and preventive care .

- 2.9.1(d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

At the heart of the Program's intent is to increase the elderly's access to, and improvement upon care management and/ or chronic care management, including education in chronic disease self-management . This will be accomplished through the direction and coordination of care services provided by the program's Patient Navigators and administrative/ support staff.

- 2.9.1(e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

With the development of the Patient Navigation program, Program leadership will include Process Milestone P-6 (Milestone #'s 5, 8, and 11) for three of the four demonstration years so that improvement opportunities can be identified and acted upon in a timely fashion. This milestone may include quality-specific activities , but are not limited to, identifying project impacts, identifying "lessons learned" opportunities to scale all or part of the Project to a broader patient population, and identifying key challenges associated with expansion of the Project, including special considerations for safety-net populations .

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: N/A

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: This project will provide for collaborative learning, coordination, and efforts between the Texas Tech University Health Sciences Center's School of Medicine, School of Nursing, and School of Pharmacy. Additionally, our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and in the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project is structured to address each of the Waiver's Triple Aims of assuring this targeted population receives the highest quality and patient-centered care, and in the most cost efficient manner. This program will clearly improve the transitions through the healthcare infrastructure making it better for all patients, including Medicaid and the uninsured. This project will enhance the development and maintenance of a coordinated care delivery system as it seeks, at its core, the ability to coordinate care for the patient. It is expected that this program will have significant contribution to better outcomes for the patients while reducing while containing healthcare cost growth. This project has the ability to "move the dial" towards a better, more coordinated patient experience, relative to the transition of the elderly from hospital-based care to community-based care.	**5**
Addresses Community Need(s)	Regional community needs *CN.1 – in part, ……. access to care, CN.4 – high incidence of obesity, diabetes, and heart disease, and CN.5 – need for specialist to assist in the treatment of obesity, diabetes, heart disease, asthma, & chronic lung* are addressed by this project- albeit, in this test of the concept, we are focused and directing the attention to some of the most-vulnerable patients in the region – our elderly. These are the patients that will get lost the easiest in our current healthcare landscape. These are the most likely to forget instruction, loose direction, misunderstand, go undiagnosed for dementia and Alzheimer's disease, etc. This project will be instrumental by ensuring proper care and treatment continue in a coordinated fashion beyond the hospital encounters. Left on their own, many elderly will be in a constant revolving door that includes hospital emergency room encounters and on-going hospitalization. This model can very likely be replicated to focus on other patient bases, but with the aging population in our region, state, and country, we felt this was the most appropriate place to begin and test the value of such a program.	**3**
Project Scope/Size	The RHP12 is made up of a large number of elderly and as "baby boomers' continue to enter the ranks of the 65+, this group of the population will be the most prolific growing patient base in the area – as it is in the country. The percent of population impacted by this intervention will grow with each passing year. The success of this project will also be recognized in the savings estimated from avoiding unnecessary emergency department encounters and hospital admissions/ readmissions.	**4**
Project Investment	This project is going to have a substantial investment given it will require hiring of operational staff, trainers, coordinators, etc. This project will take time to develop policies & procedures, organize logistics, establish an operational footprint, assess risk, and purchasing of supporting equipment. This investment, while initially large, will be worth the cost as it is expected to more than pay for itself in better patient care and reduced cost due to improved efficiencies and coordination of care.	**5**

Unique Identifier: ***084599202.2.2***	***RHP PP Reference number – 2.9.1***	***Project Components:*** ***2.9.1(a-e)***	***Transitional Care Model: From Hospital to Community- Based Care***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*[RHP Performing Provider - 137910909]*
Related Category 3 Outcome Measure(s):TBD	*084599202.3.5*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a needs assessment that validates the patient population(s) to be targeted with the Patient Navigation Program. Metric 1 [P-1.1]: Through a 'Needs Assessment," validates the targeted patient population's characteristics and demonstrates the gaps in service and service needs. Demonstrate how the program will identify, triage and manage target population (i.e. Program policies and procedures, referral and navigation protocols/ algorithms, service maps and/or flow charts) Goal: To identify and validate targeted population Data Source: Program documentation, EHR, claims, needs assessment, survey Milestone 1 [P-1] Estimated Incentive Payment *(maximum amount):* $514,895 **Milestone 2 [P-X]:** Establish a plan for	**Milestone 3 [P-3]:** Provide care management/ navigation services to targeted patients Metric 1 [P-3.1]: Establish as baseline, the number of or percent of targeted patients enrolled in the program (Total # of targeted patients enrolled in the program/ Total # of targeted patients identified). Goal: to initiate service to enrollees and establish baseline Data Source: Enrollment Reports Milestone 3 [P-3] Estimated Incentive Payment *(maximum amount):* $358,099 **Milestone 4 [I-X]:** Establish baseline of navigation program participants that utilized the ED or were hospitalized during the first year of program implementation. Metric 1 [I-X.1]: Establish baseline data to be used in conjunction with DY4 & DY5: milestones #6 & #9 on		**Milestone 6 [I-7]:** Reduce number of ED visits and/ or avoidable hospitalizations for patients enrolled in the navigation program. Metric 1 [I-7.1]: Demonstrate a 10% reduction in ED visits and/ or hospitalizations by program participants as compared to baseline established by DY3: I-X. Goal: To reduce ED event and hospital admissions of program participants Data Source: EHR, navigation program database, ED records, inpatient records Milestone 6 [I-7] Estimated Incentive Payment *(maximum amount):* $383,083 **Milestone 7 [I-9]:** Additional "Quality of Life" outcome metrics. Metric 1 [I-9.1]: Demonstrate improved clinical outcome of target population (navigation program	**Milestone 9 [I-7]:** Reduce number of ED visits and/ or avoidable hospitalizations for patients enrolled in the navigation program. Metric 1 [I-7.1]: Demonstrate a 15% reduction in ED visits and/ or hospitalizations by program participants as compared to baseline established by DY3: milestone #4. Goal: : To reduce ED event and hospital admissions of program participants Data Source: EHR, navigation program database, ED records, inpatient records Milestone 9 [I-7] Estimated Incentive Payment *(maximum amount):* $370,128 **Milestone 10 [I-9]:** Additional "Quality of Life" outcome metrics. Metric 1 [I-9.1]: Demonstrate improved clinical outcome of target population (navigation program

Unique Identifier: ***084599202.2.2***	***RHP PP Reference Number – 2.9.1***	***Project Components:*** ***2.9.1(a-e)***	***Transitional Care Model: From Hospital to Community- Based Care***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*[RHP Performing Provider - 137910909]*
Related Category 3 Outcome Measure(s):TBD	*084599202.3.5*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patient navigation recruitment; develop patient navigation policies, procedures, and protocols used as the basis for development of the "patient navigation training manual." Metric 1 [P-X.1]: Develop plan for patient navigator recruitment, training and education Goal: To initially recruit ≥ 6 motivated patient navigators Data Source: Patient navigation recruitment materials, Workforce development plan Metric 2 [P-X.2]: Develop program policies, procedures, and care protocols Goal: To establish operating policies, procedures and protocols for the program Data Source: Patient navigation Policy & Procedures Manual Metric 3 [P-X.3]: Development of Patient navigator's Training Manual Goal: To establish a training manual for the program	the number of program participants who utilized the services of the ED or was hospitalized during DY3 (#of program participants from the targeted population with ED visits and/or hospitalizations/ Total # of patient navigation participants). Goal: Establish baseline of program participants who utilize the ED or hospitalized during DY3 Data Source: Program enrollment records, EHR, navigation program database Milestone 4 [I-X]: Estimated Incentive Payment *(maximum amount):* $358,098 **Milestone 5 [P-6]:** Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation shall include 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new		participants) by ≥ 10% as compared to same measures identified through same "Data Source" of all targeted population. (Average quality of life of patients participating in the navigation program / Average quality of life of all targeted patients. Goal: ≥ 10% Improved clinical outcomes Data Source: SF-12 Health Survey, EHR and evidence-based data Milestone 7 [I-9] Estimated Incentive Payment *(maximum amount):* $383,081 **Milestone 8 [P-6]**: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation shall include 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; 3) identifying a new	participants) by ≥ 15% as compared to same measures identified through same "Data Source" of all targeted population. (Average quality of life of patients participating in the navigation program / Average quality of life of all targeted patients.) Goal: ≥ 15% Improved clinical outcomes Data Source: SF-12 Health Survey, EHR and evidence-based data Metric 2 [I-9.2]: Demonstrate improved compliance with recommended medication compliance regimens (% compliance with medication compliance regimen of patients participating in the navigation program / % compliance with medication compliance regimen of all patients.) Goal: To improve medication compliance among target population by ≥25% Data Source: EHR and evidence-based data Milestone 10 [I-9] Estimated

Unique Identifier: ***084599202.2.2***	***RHP PP Reference Number – 2.9.1***	***Project Components:*** ***2.9.1(a-e)***	***Transitional Care Model: From Hospital to Community- Based Care***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*[RHP Performing Provider - 137910909]*
Related Category 3 Outcome Measure(s):TBD	*084599202.3.5*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Patient navigation program training manual Milestone 2 [P-X] Estimated Incentive Payment *(maximum amount):* $514,895	improvements that the provider is testing; 3) identifying a new improvement and publicly commit to testing it in the weeks to come. <u>Metric 1 [P-6.1]:</u> Demonstrate number of bi-weekly meeting attended during DY3 Goal: To promote continuous learning and exchange between providers to share best practices, challenges, etc. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. <u>Metric 2 [P-6.2]:</u> Demonstrate the sharing of challenges and solutions through presentation of the quarterly summarizations of catalogued challenges, solutions, tests, and progress shared by the participating provider during bi-weekly interactions. Goal: To demonstrate idea		improvement and publicly commit to testing it in the weeks to come. <u>Metric 1 [P-6.1]:</u> Demonstrate number of bi-weekly meeting attended during DY4 Goal: To promote continuous learning and exchange between providers to share best practices, challenges, etc. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. <u>Metric 2 [P-6.2]:</u> Demonstrate the sharing of challenges and solutions through presentation of the quarterly summarizations of catalogued challenges, solutions, tests, and progress shared by the participating provider during bi-weekly interactions. Goal: To demonstrate idea exchange between providers. Data Source: Catalogue of	Incentive Payment *(maximum amount):* $370,127 **Milestone 11 [P-6]:** Demonstrate number of bi-weekly meeting attended during DY5 Goal: To promote continuous learning and exchange between providers to share best practices, challenges, etc. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-6.2]: Demonstrate the sharing of challenges and solutions through presentation of the quarterly summarizations of catalogued challenges, solutions, tests, and progress shared by the participating provider during bi-weekly interactions. Goal: To demonstrate idea exchange between providers. Data Source: Catalogue of

Unique Identifier: ***084599202.2.2***	***RHP PP Reference Number – 2.9.1***	***Project Components:*** ***2.9.1(a-e)***	***Transitional Care Model: From Hospital to Community- Based Care***	
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)				*[RHP Performing Provider - 137910909]*
Related Category 3 Outcome Measure(s):TBD	*084599202.3.5*	*Reference number(s) from RHP PP: TBD*	*Outcome Measure (Improvement Target) Title(s): TBD*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	exchange between providers. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. Could be summarized at quarterly intervals. Milestone 5 [P-6] Estimated Incentive Payment: $358,098		challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. Could be summarized at quarterly intervals. Milestone 8 [P-6] Estimated Incentive Payment (maximum amount): $383,081	challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. Could be summarized at quarterly intervals. Milestone 11 [P-6] Estimated Incentive Payment (maximum amount): $370,127
Year 2 Estimated Milestone Bundle Amount: $1,029,790	Year 3 Estimated Milestone Bundle Amount: $1,074,295		Year 4 Estimated Milestone Bundle Amount: 1,149,245	Year 5 Estimated Milestone Bundle Amount: $1,110,382
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $4,363,712				

Project Option: 2.8.1 – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Performing Provider / TPI: Texas Tech University Health Sciences Center-Lubbock/084599202
Unique Project ID: 084599202.2.3 – **"PASS 2"**
Project Components: 2.8.1.a-f

- **Provider:** The Department of Clinical Transformation is comprised of approximately fifteen (15) dedicated information technology personnel who are led by the Chief Medical Information Officer of Texas Tech University Health Sciences Center (TTUHSC). This team is involved in continued support of the electronic health records and clinical informatics.
- **Intervention(s):** This project will focus on the design, development, and implementation of a data warehouse which will be used to correlate multiple sources of information and data into more useable, functional, and proper relational data that can be used for analysis and metric reporting purposes. Currently TTUHSC has multiple sources of similar and dissimilar data that make it difficult to accurately measure and conduct comparative analysis across multiple campuses and clinical environments. Secondarily, the project will focus on the design, engineering, and implementation of a Provider Dashboard that will consolidate data in a visually appealing, digestible, and actionable format. Healthcare providers can use the dashboard to gauge their patient population's outcomes against other internal colleagues' patient bases and national evidence-based best practices. The Dashboard will also alert practitioners on which of their patients require immediate attention – either from a preventative measure to maximize optimal health or due to a chronic condition.
- **Need for the project:** The practice does not currently possess a singular, definitive means of assimilating data from multiple sources, normalizing the data, and delivery of key measures of productivity, quality, cost, & patient satisfaction in a nationally-recognized comparative format that can be used to further develop & implement evidence-based best practice processes.
- **Target population:** All patient types, without consideration or segregation amongst payer sources will directly benefit from this project's purpose, intent, and interventions.
- **Category 2 expected patient benefits:** The goal of this project is to implement process improvement methodologies to improve on patient safety, quality of care, patient experience, and delivery efficiency.
- **Category 3 outcomes:** While not totally developed, this project's Category-3 outcomes seeks to improve patient satisfaction, decrease waiting time, and have a better data integration system, which allows TTUHSC to provide better service at lower costs to achieve improved patient outcomes and satisfaction.

Project Option: 2.8.1 – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Performing Provider / TPI: Texas Tech University Health Sciences Center-Lubbock/084599202
Unique Project ID: 084599202.2.3 – **"PASS 2"**
Project Components: 2.8.1.a-f

Project Description:

Texas Tech University Health Sciences Center (TTUHSC) Department of Clinical Transformation seeks to develop and implement a Data Warehouse that will combine the data from all of the various TTUHSC sources and develop a real-time Clinical Provider Dashboard that will be operationally embedded into provider's workflow, which can be used to lower healthcare cost, improve chronic condition patient outcomes, and proactively address population health.

The Data Warehouse will receive, collate, and manage information from all TTUHSC data sources that, along with the development and implementation of a Provider Dashboard, can be utilized as a repository of registry data that:

- can be used to estimate disease prevalence and incidence,
- estimate health care resource utilization and clinical outcomes,
- track changes in parameters over time,
- Serve as data sources for conducting comparisons of health care utilization and outcomes across different categories of patients, ex: according to ethnicity, sex, age, and/or geographical location.

The Provider Dashboard will consolidate data in a visually appealing, digestible, and actionable format. Providers can use the dashboard to gauge their patient population's outcomes against other internal colleagues' patient bases and national evidence-based best practices. The Dashboard will also alert practitioners on which of their patients require immediate attention – either from a preventative measure to maximize optimal health or due to a chronic condition. The Dashboard will be interactive, so that a provider can drill down in a particular measure to identify specific patients who would most benefit from expedited intervention, in order to prevent adverse health consequences, unnecessary emergency department encounters, and/or avoidable hospital admissions. The Dashboard will also incorporate non-clinical metrics such as patient satisfaction and provider productivity, both to drive improvement to these areas and to increase provider interest and engagement with the Dashboard.

The goal of this project is to implement process improvement methodologies to improve safety, quality, patient experience, and efficiency. Through the development and implementation of the Data Warehouse and Provider Dashboard, clinicians will be able to quickly identify compliance with disease recommendations for patients. With this Dashboard, we hope to:

- Measure Meaningful Use compliance
- Track Patient Satisfaction scores at the provider level
- Promote implementation of Core Measures
- Assess compliance with patient outcomes measures
- Report performance on Quality Measures, both Ambulatory and Hospital to clinicians in as close to real time as possible, thus driving improved compliance with those measures
- Finally, to report outcomes data to clinicians in as close to real time as possible, to measure impact where it matters most (population health) and to reinforce active Quality seeking behaviors by those clinicians.

Using the data from September 2011 through August 2012, the estimated number of patients who would potentially benefit from this project is in excess of 84,500 patients. As more and more of the approximate 265 healthcare providers, and over twice as many professional nursing, technician, and patient services staff are trained and utilizing the deliverables of this project, the over 267,000 annual patient encounters of Texas Tech Physicians of Lubbock , of which approximately 106,000 equal Medicaid and Uninsured patient encounters, or approximately 40%, can be incorporated, studied and managed into more cost efficient utilization of resources and processes and provide for a clearer and more timely patient intervention that delivers better patient outcomes; all of which can be measured in accordance with national evidence-based best practices and internal comparatives. Through this project's deliverables, both increases and decreases in current service utilizations will result from better, more timely and more comprehensive management over resource utilization and clinical outcomes.

Required core project components:

A. Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
    - Provide Six Sigma and LEAN training to MBA prepared Clinic Administrators, directors, and interested Providers
    - Work with Continuing Medical Education Department to provide CEU's for physicians regarding optimization of

patient outcomes directly tied to data parameters, based on specialty/subspecialty

- Work collaboratively with Engineering Department of Texas Tech University (relationships already exist) to analyze and perform simulations and projection modeling to conduct analysis that assist in appropriate decision-making opportunities regarding improvement strategies, methodologies, and culture.

B. Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

- Continue to market the Hot Line and the organizations on-site Patient Advocate phone number and location to anonymously report patient care and satisfaction issues.
- Conduct "Town Hall' meetings and "Focus Groups" to get feedback from employees regarding opportunities for continuous process improvement
- Provide forms for employees to submit continuous process improvement ideas to the Director of Performance Improvement at all mandatory annual training events and personally provide forms and encourage employee input at annual performance evaluations conducted by Supervisors.

C. Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures (i.e. weekly or monthly dashboard).

- Centricity (IDX), Press-Ganey, and EHR data will be mined electronically for real time data and as necessary, manually (periodically) for retrospective data that cannot be mined electronically for the following measures and outcomes on all of the measures will be visible on a single screen embedded into the physician workflow:
    - Meaningful use criteria compliance
    - PQRS measures compliance
    - Appointment access availability
    - Quantity of visits and procedures
    - High volume diagnosis with tracking of associated outcomes
    - RVU's
    - Press-Ganey (CG Caps) patient satisfaction scores
    - Referral patterns
    - Population management percentages in compliance with best 'recommended practices for chronic disease management
    - Visit level patient information and demographics
    - Service
    - Financials

D. Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.
   - Clinic workflow is driven by staffing and care coordination models are and continually assessed and analyzed to achieve optimal efficiencies. Improved data transparency is achieved through development, implementation, and analysis of physician dashboard monitors and external/internal benchmarking will significantly enhance identification of PI opportunities.

E. Implement software to integrate workflows and provide real-time performance feedback.
   - Work collaboratively with Industrial Engineering Department of Texas Tech University (relationships already exist) to analyze, develop, and test simulation models based on mined data components reflecting real time information to make recommendations regarding actionable scheduling and staffing workflows

F. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.
   - Performance Improvement data is reviewed monthly by interprofessional team of physicians, administrators, staff, and organizational leadership to identify trends and opportunities for clinical and operational performance improvement.

Currently, physicians are not able to quantify their patient population's data against best practice, evidence-based patient care data. The dashboard will seek to address this dilemma by alerting providers which patients are due for a regular visit, which patients have not done physicals, and other information that allows physicians to track patient outcomes.

The five-year expected outcome is to improve patient satisfaction, decrease waiting time, and have a better data integration system, which allows TTUHSC to provide better service at lower costs to achieve improved patient outcomes.

Starting Point/Baseline: Currently a Provider Dashboard described above does not exist and Performance Improvement monitoring is retrospective and very limited at best vs. developing and implementing the proposed tool which will be real time and include 100% of the provider's patient population being served.

Rationale: Every day, millions of Americans receive high-quality health care that helps to maintain or restore their health and ability to function. However, far too many do not. Quality problems are reflected in a wide variation in the use of health care services, underuse of some services, overuse of other services, and misuse of services, including an unacceptable level of errors. A central goal of health care quality improvement is to maintain what is good about the existing health care system while focusing on the areas that need improvement. Several types of quality problems in health care have been documented through peer-reviewed

research. *(http://www.ahrq.gov/news/qualact.htm)*

Variation in services: There continues to be a pattern of wide variation in health care practice, including regional variations and small-area variations. This is a clear indicator that health care practice has not kept pace with the evolving science of health care to ensure evidence-based practice in the United States.

Underuse of services: Millions of people do not receive necessary care and suffer needless complications that add to costs and reduce productivity. Each year, an estimated 18,000 people die because they do not receive effective interventions in a timely manner.

Overuse of services: Each year, millions of Americans receive health care services that are unnecessary, increase costs, and may even endanger their health. Research has shown that this occurs across all populations.

Misuse of services: Too many Americans are injured during the course of their treatment, and some die prematurely as a result.

Disparities in quality: Although quality problems affect all populations, there may be specific groups identified that have marked differences in quality of care and health outcome. These groups may be defined by racial/ethnic differences, income states, geographic area, or other social determinants of health.

The healthcare industry is plagued by data overload, but information is sparse. The Electronic Health Records system allows for efficient gathering of data concerning patients and diseases. But, data may be stored in an EHR system and later forgotten; which contributes to, and manifest into the "DRIP" syndrome ("Data Rich, Information Poor"). A dashboard provides physicians with real-time information regarding their key performance metrics.

The following community needs, as summarized from the RHP12 Urban and Rural Community Needs Assessment, have been determined and are specifically addressed by this project: (1) CN.4 – High incidence of obesity, diabetes mellitus, and heart disease – the Dashboard will alert providers to those within their patient base that are most at-risk for these and other potentially chronic disease states; (2) CN.5 – Need for specialist to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung – the Dashboard will get specialist providers engaged more quickly as patients with chronic conditions are managed more effectively; (3) CN.6 – Need for cancer screenings and mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam – the Dashboard will provide each provider real-time comparative data on preventive services appropriately directed to their patient base as compared to other internal provider patient bases and "best practice" standards; (4) CN.7 – Insufficient maternal and prenatal care, especially the first trimester teen pregnancy, high percentage of unmarried mothers – once fully developed and tested in the TTUHSC Department of Family Medicine, the Dashboard will be implemented and employed by the Department of Obstetrics & Gynecology and will specifically address the above community need for more timely and appropriate care and education. Each of the four community needs enumerated above meet the region's "urgent need" criteria.

Related Category 3 Outcome Measure(s): TBD

Relationship to other Projects: 2.7.1: Project Title: "ACT" Project: Assimilate quality data into the electronic health record Comprehensive health history and health maintenance data processed through an Electronic Health Record-generated Clinical Decision Support Engine Transform Cardiovascular Disease outcomes through empowerment of providers and patients

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and in the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project directly addresses the Waiver goals of expanding preventive care, assuring that appropriate care is being delivered timely and in the appropriate setting, and reducing the cost of healthcare through the reduction of preventable emergent care issues that result from the lack of appropriate or timely health care intervention. The Dashboard will initially be engineered to provide comparative, both internal among peers and national "best practice" standards, patient base data at the practitioner and patient level that can be used as "the monitor" to ensure that a practitioner's patient population is being managed in the most efficient, and effective means of administering for optimal health or minimal intrusion from chronic health conditions.	**5**
Addresses Community Need(s)	The following community needs have been determined and are specifically addressed by this project: (1) *CN.4 – High incidence of obesity, diabetes mellitus, and heart disease* – the Dashboard will alert providers to those within their patient base that are most at-risk for these and other potentially chronic disease states; (2) *CN.5 – Need for specialist to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung* – the Dashboard will get specialist providers engaged more quickly as patients with chronic conditions are managed more effectively; (3) *CN.6 – Need for cancer screenings and mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam* – the Dashboard will provide each provider real-time comparative data on preventive services appropriately directed to their patient base as compared to other internal provider patient bases and "best practice" standards; (4) *CN.7 – Insufficient maternal and prenatal care, especially the first trimester teen pregnancy, high percentage of unmarried mothers* – once fully developed and tested in the TTUHSC Department of Family Medicine, the Dashboard will be implemented and employed by the Department of Obstetrics & Gynecology and will specifically address the above community need for more timely and appropriate care and education. Each of the four community needs enumerated above meet the region's "urgent need" criteria.	**5**
Project Scope/Size	With full implementation of the Provider Dashboard throughout the TTUHSC-Lubbock, ~275 provider multi-specialty group, the patient population positively impacted is quite large.	4
Project Investment	To establish the infrastructure and technological logistics required for a data warehouse and develop/ engineer the Provider Dashboard for continuous , rapid process improvement internally will require a rather substantial and sustained investment by TTUHSC-Lubbock	4

084599202.2.3 – "PASS 2"	RHP PP Reference number: 2.8.1	Project Component(s): 2.8.1 (a-f)	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)			TPI: 084599202
Related Category 3 Outcome Measure(s):	084599202.3.6	TBD	TBD

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-3]: Compare and analyze clinical/ quality data for three patient conditions targeted for improvement. Metric 1 [P-3.1]: The Performing Provider will initially analyze and identify three (3) target areas. Goal: To improve on patient care quality by providing timely, condition-specific diagnosis, status, and treatment care based on three (3) underlying condition/ illness; e.g.: diabetes, cardiovascular disease, etc. Data Source: Performing Provider report demonstrating targeted areas for improvement. Milestone 1 Estimated Incentive Payment (maximum amount): $455,922.50 **Milestone 2 [**P-2]: Identify/ target metric(s) to measure the impact of the improvements associated with the specific patient/ clinical	**Milestone 3 [**P-10]: Develop a quality dashboard that will quantify and determine the quality of care provided. Metric 1 [P-10.1]: Submission of quality dashboard development, utilization, and results. Goal: To provide clinicians with a provider dashboard that includes relevant patient care metrics and data to support and ensure patient care compliance with specific health conditions ongoing review, diagnostic and treatment requirements for both optimal health and specific-condition management. Data Source: Dashboard software, policies, and procedures for use and sample dashboard report. Milestone 3 Estimated Incentive Payment (maximum amount): $303,541.66 **Milestone 4 [**P-8]: Train	**Milestone 6 [**P-X]: Expand dashboard to include other key performance indicators (KPIs) to include, but not limited to, quality, financial, patient satisfaction, etc. and add additional clinical departments to its use. Metric 1 [P-X.1] Engineer additional KPIs into the quality/ patient care dashboard created by Milestone 3 [P-10] **Goal:** To build in more versatility and value into the Provider Dashboard thereby advancing its utilization and quality of care value. **Data Source:** Submission of the latest version of the Provider Dashboard demonstrating the enhancements over the prior demonstration year. **Metric 2 [P-X.2]** Add additional clinical departments (departments of pediatrics and internal medicine) to the use of the Provider Dashboard. **Goal:** To expand the use of the Provider Dashboard by training and	**Milestone 9 [**P-X]: Expand dashboard to include other key performance indicators (KPIs) to include, but not limited to, quality, financial, patient satisfaction, etc. and add additional clinical departments to its use. Metric 1 [P-X.1] Engineer additional KPIs into the quality/ patient care dashboard created by Milestone 3 [P-10] **Goal:** To build in more versatility and value into the Provider Dashboard thereby advancing its utilization and quality of care, adding, at a minimum, financial, patient satisfaction, and quality indicators. **Data Source:** Submission of the latest version of the Provider Dashboard demonstrating the enhancements over the prior demonstration year. **Metric 2 [P-X.2]** Add additional clinical departments to the use of the Provider Dashboard. **Goal:** To expand the use of the

084599202.2.3 – "PASS 2"	RHP PP REFERENCE NUMBER: 2.8.1	PROJECT COMPONENT(S): 2.8.1 (A-F)	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)			TPI: 084599202
Related Category 3 Outcome Measure(s):	084599202.3.6	TBD	TBD

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
conditions targeted for improvement to establish baselines for future improvement comparatives. Metric 1 [P-2.1]: Performing Provider identification of impact metrics and establishment of baseline. Goal: To improve on patient care quality by providing timely, condition-specific diagnosis, status, and treatment care based on underlying condition/ illness; e.g.: diabetes, cardiovascular disease, etc. through the establishment of impact metrics and baselines. Data Source: Performing Provider report demonstrating identification of metrics and establishment of baseline metrics Milestone 2 Estimated Incentive Payment (maximum amount): $455,922.50	providers/staff in process improvement Metric 1 [P-8.1]: Number of providers/staff trained. Goal: To increase exposure to the dashboard tool and increase the clinician's confidence in the information and utilization by initially training and implementing the dashboard tool in the department of family and community medicine. Data Source: Provider supplied evidence supporting the training and implementation of the provider dashboard in the department of family and community medicine. Metric 2 [P-8.2]: Number of trainings held. Goal: To ensure maximum understanding of the dashboard, the data being reported and its applicability to the improvement of patient care, the project will	implementing in the departments of pediatrics and internal medicine. Data Source: Performing Provider provided documentation demonstrating other clinical department's utilization. Milestone 6 Estimated Incentive Payment (maximum amount): $309,013.33 **Milestone 7 [**I-16]: Measure improvement in targeted areas over baselines established by Milestone 2 in DY2. Metric 1 [I-16.2]: Demonstrate equal to, or improvement in the 3 patient conditions targeted by Milestone 1 [P-3]. Goal: Demonstrate a ≥ 10% improvement from baselines established by Milestone 2 in DY2. Data Source: Performing Provider Analysis Milestone 7 Estimated Incentive Payment (maximum amount): $309,013.33	Provider Dashboard value, add remaining eight (8) Texas Tech Physicians of Lubbock clinical departments, trained & actively utilizing the provider dashboard. **Data Source:** Performing Provider provided documentation demonstrating other clinical department's utilization. **Milestone 9 Estimated Incentive Payment:** $287,046.33 **Milestone 10 [**I-16]: Measure improvement in targeted areas over baselines established by Milestone 2 in DY2. Metric 1 [I-16.2]: Demonstrate equal to, or improvement in the 3 patient conditions targeted by Milestone 1 [P-3]. Goal: Demonstrate a ≥ 15% improvement from baselines established by Milestone 2 in DY2. Data Source: Performing Provider Analysis Milestone 10 Estimated Incentive

084599202.2.3 – "PASS 2"	RHP PP Reference Number: 2.8.1	Project Component(s): 2.8.1 (a-f)	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)			TPI: 084599202
Related Category 3 Outcome Measure(s):	084599202.3.6	TBD	TBD

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	ensure a minimum of 4 quarterly training sessions associated with the rollout of the provider dashboard. Data Source: Curriculum or other training schedules/ materials Milestone 4 Estimated Incentive Payment (maximum amount): $303,541.66 **Milestone 5 [**I-16]: Measure improvement in targeted areas over baseline established in DY2 via Milestone 2 [P-2] Metric 1 [I-16.2]: Using metrics identified and baselines established in DY2, demonstrate improvement in the 3 patient conditions targeted by Milestone 1 [P-3]. Goal: To demonstrate a 10% improvement in metrics over baselines established previous DY Data Source: Analysis by Performing Provider	**Milestone 8 [**P-15]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Metric 1 [P-15.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: To promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations and/or meeting notes Metric 2 [P-15.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting	Payment (maximum amount): $287,046.33 **Milestone 11 [**P-12]: Report findings and learning's. Metric 1 [P-12.1]: Submission of Final report/ report summary Goal: To report on whether the process improvement methodology was able to show improvement on a selected measure for learning purposes within and beyond the safety net. Data Source: All data sources used for and during the process improvement event(s) Milestone 11 Estimated Incentive Payment (maximum amount): $287,046.33

084599202.2.3 – "PASS 2"	RHP PP REFERENCE NUMBER: 2.8.1	PROJECT COMPONENT(S): 2.8.1 (A-F)	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Texas Tech University Health Sciences Center – Lubbock (TTUHSC-LBK)			TPI: 084599202
Related Category 3 Outcome Measure(s):	084599202.3.6	TBD	TBD

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 5 Estimated Incentive Payment (maximum amount): $303,541.66	Goal: Top promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations and/or meeting notes Milestone 8 Estimated Incentive Payment (maximum amount): $309,013.33	
Year 2 Estimated Milestone Bundle Amount: $911,845	Year 3 Estimated Milestone Bundle Amount: $910,625	Year 4 Estimated Milestone Bundle Amount: $927,040	Year 5 Estimated Milestone Bundle Amount: $861,139
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,610,649			

Project Option: 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.2.1

Project Description:
University Medical Center (UMC) will adopt a performance improvement methodology such as LEAN / Six Sigma.

- **Provider:** University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.
- **Interventions(s):** This project will change or extend the way patients are cared for in the ambulatory setting. Care teams will be implemented within designated ambulatory clinics within PNS or Texas Tech, consisting of independent practitioner and case manager or "coach." Utilizing information from the disease registry, patients within a chronic disease category (example: diabetes) will be seen by their care team. Case Managers and Pharmacists will make phone visits, perhaps group visits and in-home visits. Patient "self-management goals" will be a component as well, in an effort to engage patients toward better health. This will require establishment of these goals via education provided by care teams. The team will utilize information provided through our membership with QUEST by Premier. This information will be used to focus on rapid cycle improvement; once a trend is noted via disease registry, we will continue to rapidly implement PCDA, learning from our results, re-assessing, and implementing improvements.
- **Need for the project:** The community needs assessment identified a large number of residents attempting to manage chronic conditions including, but not limited to, heart failure, diabetes and asthma. UMC has seen initial positive results from inpatient management (education) and post-discharge outreach in CHF readmissions. It is believed that a more robust and organized outpatient care management model could have a more significant impact on the chronic needs of the patients served.
- **Target population:** The target population will be all patients 18 through 75 years of age, seen/managed in designated ambulatory clinics within PNS or Texas Tech. . Initial needs assessment demonstrated that approximately 1000 patients with a chronic disease such as hypertension and diabetes, with Medicaid or unfunded, are being seen in identified outpatient clinics.
- **Category 1 or 2 expected patient benefits:** This project seeks to improve quality of life, clinical indicators, and quality outcomes of the defined patient population suffering from chronic health conditions. In DY2, the expected patient benefit is to identify patients at the selected clinics who are funded with either Medicaid or unfunded and who have a chronic disease such as hypertension or diabetes. (Data from 2012 identified approximately 1000 patients in selected outpatient clinics with a chronic disease and having Medicaid no insurance.) In DY3, the expected patient benefit is to have at least 25% or 250

patients involved in the care coordination project. In DY4, the expected patient benefit is to have at least 40% (or 100 patients) of patients in the care coordination project to be enrolled in a care management program. In DY5, the expected patient benefit is to have 100% (or 100 patients) of patients enrolled in the care management program to have at least one self-management goal.

- **Category 3 outcomes:** IT-1.12 Diabetes Care – Retinal Eye Exam, IT-1.13 Diabetes Care – Foot Exam, and IT-1.14 Diabetes Care – Microalbumin/nephropathy. The goal is to increase the number of patients receiving these screening exams in the identified clinic locations.

Project Option: 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Performing Provider: University Medical Center - 137999206

Unique Identification Number: 137999206.2.1

Project Components: 2.2.1.a-e

- **Project Description – Project Option 2.2.1:** To expand chronic care management models means to change or extend the way patients are cared for in the ambulatory setting, and to do so beyond the typical office visit or intervention. Care management coordinates the entire team around a chronic disease diagnosis, including provider, pharmacist, case manager or outreach nursing (i.e., coach) for the purpose of improving outcomes for a defined population. Outcomes can range from medication/therapy compliance to reduced admissions and/or readmissions. With a shortage of primary care providers (worsening potentially in 2014) and the increase in chronic disease (i.e., diabetes per our community assessment), dependence upon a team effort within an expanded model is necessary. In recent years, CMS sponsored several demonstration projects in which CMS noted improvements in patient outcomes through a more intensive oversight of their chronic care. Logistically, this expansion of chronic care management will incorporate creative formats such as telephone visits, group visits and other means of establishing trust with clientele. One of the major components is the establishment of self-management by patients….they set their goals and receives coaching toward success.

  Describe the process of implementation:
  - Determine designated clinics to house the new process
  - Utilize the soon-to-be-purchased disease registry; select a chronic condition to follow (example: diabetes)
  - Hire "coaches" whether RN Case Managers, Social Workers or even Pharm Techs
  - Create care teams – and ensure they are trained on disease registry input and output
  - Determine performance duties – who makes phone/personal visits; how to document "coaching"
  - Perform PDCA – plan, do, check, act – based on patient feedback and outcomes – what was learned?

  Discuss the major components of the project including any required components
  - Core component (a.) *Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via telephone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system*. - Care teams will be implemented within designated ambulatory clinics within PNS or Texas Tech, consisting of independent practitioner

and case manager or "coach." Utilizing information from the disease registry, patients within a chronic disease category (example: diabetes) will be seen by their care team. Case Managers and Pharmacists will make phone visits, perhaps group visits and in-home visits. These interactions will be best described as coaching toward improved outcomes.

- Core component (b.) *Ensure patients can access their care teams in person or by phone or mail.* - Patients will have ready access to their care team….research has indicated that chronic condition readmissions also include a psychological component…anxiety about a worsening symptom creates a trip to the ER…thus, our goal is to have patients contact their care team, instead of pursuing the normal route to the ER.
- Core component (c.) *Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources*. - Patient "self-management goals" will be a component as well, in an effort to engage patients toward better health. This will require establishment of these goals via education provided by care teams.
- Core component (d.) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.* - Empowering of patients via education, support (physical and emotional), and email/phone communication.
- Core component (e.) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.* We are members of QUEST by Premier, focusing on rapid cycle improvement; once a trend is noted via disease registry, we will continue to rapidly implement PCDA, learning from our results, re-assessing, and implementing improvements.

Our population will be all patients 18 through 75 years of age, seen/managed in designated ambulatory clinics within PNS or Texas Tech.

- **Project Goals:** Our goals are to improve quality of life, clinical indicators, and quality outcomes of the defined patient population suffering from chronic health conditions. Each step taken (phone call, education, resources) is done with the intention of lowering the risk of another visit/hospitalization/expense.
- **Challenges:** The primary challenges associated with an aggressive chronic care management system are gaining the acceptance of the system by the physicians and the patients. Physicians may not readily accept others aiding in the management of their patients. We will incorporate physicians in the development and implementation of the system to

achieve buy-in. Physicians will then need to manage the system up to patients and help them understand the benefits of the process. Case workers will need to gain the trust of patients and build a relationship that will facilitate the management of the patient health care process.

- **5-Year Outcome: List the major goals expected to be achieved in 5 years:**
    - Established suitable volume of patients who have utilized self-management goals toward improved outcomes
    - Reduced readmissions/admissions for specific chronic conditions
    - Expanded project through additional clinics, and incorporating further chronic conditions
    - Improved patient outcomes via disease registry monitoring (i.e., more patients compliant with foot exams – diabetes)
- **Relationship to Regional Goals:** The region's primary goals are to be responsive to the issues identified in the community needs assessment and to achieve progress towards the triple aim goals of improving the patient experience including quality and satisfaction, improving the health of populations and reducing the per capita cost of care. This project will contribute towards improving the quality and satisfaction of the patient and reduce the associated cost of providing care by implementing a chronic care model that provides patient-centered management of the disease process and empowers the patient to self-manage their care through guidance and education. This project directly impacts CN.1 as it relates to cost of care and access to primary care and CN.5 for addressing the health care needs of those with chronic conditions.
- **Starting Point/Baseline:** Volume of outpatients registered with a chronic care mgt model: 0
- **Rationale:** Our community assessment indicates a large number of residents attempting to manage chronic conditions (CN.5) which include hypertension diabetes and asthma. At UMC, we have seen initial positive results from inpatient management (education) and post-discharge outreach, specifically a reduction in congestive heart failure (CHF) readmissions. This provides rationale for implementation of a more robust outpatient (clinic) care management model. Chronic conditions are burdensome to patients, but also to care givers who have limited time for life and habit changing intervention. Thus, case managers (coaches and coordinators) are utilized to facilitate the benefits of patients' self-care. This builds upon related projects including implementation of a chronic disease registry. Readmissions cost UMC - both in direct expense for self-pay/Medicaid volume but also in CMS penalties for targeted readmissions within the Medicare volume.

All required components have been included in this project. The first component, design and implement care teams that are tailored to the patient's health care needs is the foundation of this project. The next components, ensuring that patients can access their care teams, increasing patient engagement and implementing projects to empower patients to make lifestyle changes to stay health and self-manage their chronic conditions will be critical in a successful outcome. These components were selected because of the need for patient involvement in their care. Because access to care is an ongoing issue in this region, a patient that has a better understanding of their condition, the framework for addressing their condition and a

process to access the right care at the right time will have an overall better outcome than those that do not. The final component, conducting quality improvement for the project will ensure that UMC continues to raise the bar on the expected performance of this project and rapidly responds to issue that may interfere with that goal. Process Milestone P-9 is the development of a program to identify and manage chronic care patients needing further clinical intervention. Initial needs assessment demonstrated that approximately 1000 patients with a chronic disease such as hypertension and diabetes are being seen in identified outpatient clinics. This is the backbone of this project. The chronic care management project will need an efficient and effective method of facilitating care for the chronic patients. Process Milestone P-10 is expansion and documentation of interaction types between the patient and the health care team. This second step in the project works towards building a relationship of trust between the patient and the health care team. This relationship and the communications that come from it will facilitate the progress towards building a long-term commitment to address chronic conditions. Process Milestone P-11 focuses on working with the patient to become part of the care team by educating them on self-management of their chronic condition. Improvement milestone I-18 measures the number of patients with self-management goals. This is an effective metric to determine whether or not the program is connecting with the patients. UMC does not currently have a formalized system to effectively coordinate care for patients with chronic diseases. Therefore this is a new initiative for the organization.

- **Related Category 3 Outcome Measure(s):**
  Outcome Domain: OD-1 Primary Care and Chronic Disease Management
  Improvement Targets: IT – 1.12 Diabetes Care - Retinal Eye Exam, IT 1.13 Diabetes Care - Foot Exam and IT – 1.14 Diabetes Care - Microalbumin/nephropathy.
  The goal of the project is to improve the care provided to patients with chronic conditions. This includes the management of patients with chronic conditions in ambulatory settings. These outcome measures will identify the effectiveness of the outreach to chronic patients and identify the effectiveness of measures implemented to insure patients are involved in their care management. This project will guide patients with chronic conditions to get evidenced based care to improvement their well-being and reduce long-term costs associated with their care.
- **Relationship to other Projects:** This project relates to Implementation of 1379992061.1 1.3 Chronic Disease Management Registry and 137999206.2.3 Conduct Medication Management. This project will utilize the registry to be implemented and will be focused on addressing the health needs of diabetics along with the medication management project.
- **Relationship to Other Performing Providers' Projects in the RHP:** N/A
- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately

better served the populations in their projects. In addition to face-to-face meetings, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Triple Aim goals are directly impacted by chronic care management because caregivers involved (i.e., case managers, coaches and other nursing personnel) establish trust-relationships with chronically ill patients, many of which readmit to the hospital due to anxiety regarding symptoms as well as the symptoms themselves. These relationships provide a valuable "go to" person not just in the hospital, but now in the clinic and on the phone. This project builds a stronger infrastructure by extending the continuum of care into the patient's residence as necessary.	**5**
Addresses Community Need(s)	As with the Disease Registry, the expansion of a chronic care management model is foundational to our effort to address community needs. The Lubbock community has significant volumes of chronically ill patients (diabetes, CHF, etc.) and this investment will build upon initial success already seen by UMC.	**5**
Project Scope/Size	This project will vary in size based on the number of diagnoses groups undertaken. As far as direct results (tying specific interventions to a desired outcome) the impact will be significant, again based on initial results.	**4**
Project Investment	The investment is essentially all human resources - nursing staff who are trained and available to build trust relationships with patients, strengthened by pharmacists, social workers, and other disciplines who provide a patient-centered approach, with the intention of reducing risk, reducing anxiety about his/her condition and increasing level of self-care.	**5**

137999206.2.1	2.2.1	2.2.1.a-e	Project Title: Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
University Medical Center			137999206
Related Category 3 Outcome Measure(s):	137999206.3.4 137999206.3.5 137999206.3.6	IT-1.12 IT-1.13 IT-1.14	Diabetes Care – Retinal Eye Exam Diabetes Care – Foot Exam Diabetes Care – Microalbumin/Nephropathy

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [2.2 P-9] Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1: [2.2 P-9.1] Increase the number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal: There is currently no process in place to identify this group of patients. The goal is to begin to identify chronic care patients. Numerator: Number of patients identified and subsequently receiving needed tests or other clinical services Denominator: Number of patients identified as needing screening test, preventative tests, or other clinical services (Approximately 1000 patients at 3 identified clinics) Data Source: Cerner EHR Estimated Milestone 1 Incentive Payment:$2,427,993	*Milestone 2: [2.2 P-10]* Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types *Metric 1: [2.2 P-10.1]* Increase the number of group visits and/or telephone visits and/or other interaction types. Baseline/Goal: There are currently no group or telephone visits for chronic patients. The goal would be to start having group or telephone visits with the identified chronic care patients and to have at least 25% or 250 patients involved in the care coordination project *Data Source: EHR and billing records* *Estimated Milestone 2 Incentive Payment:* *$2,648,810*	*Milestone 3: [2.2 P-11]* Develop and implement program to assist patient to better self-manage their chronic conditions *Metric 1: [2.2 P-11.1]* Increase the number of patients enrolled in a self-management program Baseline/Goal: No patient currently enrolled in a self-management program. Goal is for 40% or 100 patients to be enrolled in a self-management program. Numerator: Number of patients enrolled in a self-management program for a given chronic condition Data source: EHR, patient registry, class enrollment and attendance records Estimated Milestone 3 Incentive Payment: $2,656,510	*Milestone 4: [2.2 I-18]* Improve the percentage of patients with self-management goals *Metric 1: [2.2 I-18.1]* Patients with self-management goals Baseline/Goal: No patients currently with self-management goals. Goal is for 100% (or 100 patients) of registry patients enrolled in a self-management plan to have a self-management goal. Numerator: Number of patients with the specific chronic condition/MCC in the registry with at least one recorded self-management goal. Denominator: Total number of patients with the specified chronic conditions/MCC in the registry. Data Source: Registry Estimated Milestone 4 Incentive Payment: $2,194,508

137999206.2.1	2.2.1	2.2.1.a-e	Project Title: Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
University Medical Center			137999206
Related Category 3 Outcome Measure(s):	137999206.3.4 137999206.3.5 137999206.3.6	IT-1.12 IT-1.13 IT-1.14	Diabetes Care – Retinal Eye Exam Diabetes Care – Foot Exam Diabetes Care – Microalbumin/Nephropathy

DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
DY 2 Estimated Milestone Bundle Amount: $2,427,993	DY 3 Estimated Milestone Bundle Amount: $2,648,810	DY4 Estimated Milestone Bundle Amount: $2,656,510	*DY5 Estimated Milestone Bundle Amount: $2,194,508*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $9,927,821			

Project Option: 2.3.2 "Other" project option: Redesign Primary Care
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.2.2

Project Description:

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- **Provider:** University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.
- **Interventions(s):** This project is designed to implement the SNFist model within the nursing home facility setting. A SNFist is an MD, a specialist with expertise/training/interest in geriatric medicine who manages the health status of nursing facility residents. UMC will establish relationships with nursing homes interested in the value-added proposition of a SNFist practitioner on-site. SNFist practitioners will be hired and put in place. A plan will be developed to improve the timeliness and frequency of care provided to the high-risk, geriatric nursing home patients. Staff in the nursing facilities will be trained on the SNFist model, its goals and objectives. A PDCA monitoring of both readmissions to UMC reductions and readmission to all facilities will be developed to monitor the success of the project.
- **Need for the project:** The community needs assessment identified a significant population of nursing home patients with 10% to 20% of residents in an acute care facility at any given time. Readmissions for chronic conditions including CHF, diabetes and COPD and admission for symptom management such as pain, flu and UTI impact the elderly population and increases the overall cost of providing care to this population. A SNFist provides a proactive on-site continual assessment of pain, skin breakdown, chronic comorbid conditions, etc.
- **Target population:** The target population will be all patients residing in targeted nursing home facilities, approximately 350 patients. The patients in these nursing homes are principally Medicaid and Medicare.
- **Category 1 or 2 expected patient benefits:** The expected patient benefit by DY is as follows: DY3 our goal is to have 28.5% or 100 patients under SNFist care. By DY4 our goal is to have 42.8% or 150 patients under the SNFist care. By DY5 we will have 57% or 200 patients under the SNFist care.
- **Category 3 outcomes:** IT-3.1 30 day all cause readmission rate. The project is intended to reduce the 30 day all cause readmission rate for the target population.

Project Option: 2.3.2* "Other" project option: *Redesign Primary Care
Performing Provider: University Medical Center - 137999206
Unique Identification Number: 137999206.2.2

- **Project Description – Project Option 2.3.2:** As an "Other Project" option, this project is to implement a SNFist model within a nursing home facility(s). A SNFist is defined as an MD, whether internist or family medicine practitioner, a specialist with expertise/training/interest in geriatric medicine, who manages the health status of nursing facility residents (patients). This model will be implemented within a nursing home facility(s) associated with University Medical Center via medical directors. The reason for this model – is due to the fact that nursing home patients end up in the hospital, often unnecessarily. That is the presumption argued in current literature. A SNFist sees nursing home patients as primary duty, and develops a particular understanding of the potential and limitations of the SNF as a care setting. The SNFist is typically paid a salary or contracting fee by the nursing home or the medical director overseeing assigned patients within the facility. Literature also suggests that due largely to acute-care hospitals' efforts to reduce length of stay, nursing homes are admitting more patients who are still quite sick or fragile and require a high level of medical care. Jose Gonzales, MD, medical director of Extended Care Physicians in Wilmington NC, said, "We're now receiving patients in SNFs that 10 to 20 years ago would still be in acute care hospitals." An increasing shortage of primary care physicians renders this option more appealing. Preventable hospitalizations are much more expensive than treating a nursing home patient on site. Additionally, transfers to the hospital and back to the nursing home expose patients to elevated risks – namely hospital acquired conditions. This option serves to increase the amount of time a physician (SNFist) spends with nursing home patients and, to decrease the time to takes to get a doctor to the bedside of a patient whose condition shows signs of deteriorating.

- The process of implementation will be as follows:
    - Establish workable relationships with select nursing homes, interested in the value-added proposition of a SNF-ist practitioner on-site. Validate via contractual agreements.
    - Recruit and hire SNF-ist practitioner(s).
    - Develop PDCA (plan do check act) monitoring of both readmission to UMC reduction measurement (hospital side) as well as readmission to all facilities reduction measurement (nursing facility side). These will stand as metrics of success.
    - Train staff in nursing facilities on the SNF-ist model, its goals and objectives.

- The population for this project will be all patients (all payers, but principally Medicaid and Medicare) residing in targeted nursing home facilities, chosen for inclusion in this project.

- **Project Goals:** The goals of the program are:
    - reduced readmissions and thus reduced cost to the payers;
    - avoided admissions via quicker interventions, improved response time from providers who are on-site;
    - improved patient and family satisfaction – particularly as families (decision makers) have greater access to providers;
    - improved care – ranging from medication management, fall prevention and decubitus reduction (all manner of hospital acquired conditions).
- **Challenges:** This project will rely upon building relationships with nursing homes, medical directors of nursing homes and patients to be successful. This will be its greatest challenge. This new process could be viewed by some as disrupting existing patient care processes that are no longer effective and efficient. The SNFist will need to build those relationships and work collaboratively with existing care providers to improve the way health care is delivered to the population.
- **5-Year Outcome – List the major goals to be achieved in 5 years:**
    - Readmission rates (all payers) from select nursing facilities to be below national rates, and at CMS threshold
    - Expanded process beyond initial nursing facilities – governed by a medical direction in charge of several SNF-ist practitioners, with standardized approaches toward improvements
- **Relationship to Regional Goals: :** The regions primary goals are to be responsive to the issues identified in the community needs assessment and to achieve progress towards the triple aim goals of improving the patient experience including quality and satisfaction, improving the health of populations and reducing the per capita cost of care. This project will contribute towards improving the quality and satisfaction of the patient and reduce the associated cost of providing care by increasing the amount of time that the physician spends with the patient and early identification of deterioration of a patient, thus getting the patient more timely intervention and either avoiding a hospitalization or reducing the time the patient stays in a facility. Additionally, the SNFist will participate in post-acute care in an effort to reduce hospital readmissions. This project directly impacts CN.1 as it relates to cost of care an access to primary care, CN.3 and care of the unfunded or underfunded, and CN.5 and care for those with chronic conditions.
- **Starting Point/Baseline:** There are currently no patients under the care of a SNFist within designated nursing facility(s). Therefore, the baseline will consist of a) initial readmission rates from select nursing facilities to UMC, and b) initial readmission rates from select nursing facilities to all acute care hospitals.

- **Rationale:** According to the Journal of the American Geriatric Society, one study in Georgia found that 2/3 of nursing home readmissions were potentially avoidable. In Lubbock County, a needs assessment determined a significant population of nursing home residents, with 10% to 20% in an acute care facility at any one time. Readmissions for chronic conditions (CHF, Diabetes, COPD) and admissions for symptom management (pain, flu, UTI) affect the elderly population and the cost is increasing. Families become alarmed at the condition of their loved one upon visiting the nursing facility – an easy option for the nurse on duty is to seek a transfer to the hospital ER. A SNFist provides a proactive on-site continual assessment of pain, skin breakdown, chronic comorbid conditions, etc. Readmissions are reduced, admissions are avoided, patient and family satisfaction (and thus therapeutic compliance) increases, and finally overall cost reduces. In addition to on-site management of facility residents, a SNFist may also assume care of admitted patients within the hospital. This provides a particularly helpful service as patients and families experience a consistent level of knowledge and care from their provider. Obvious benefits range from admit and discharge medication management to consistent nutritional service. Given the prevalence of hospital acquired infections, an avoided hospital stay is considered a definitive step toward improved overall health. This project directly impacts CN.1 as it relates to cost of care an access to primary care, CN.3 and care of the unfunded or underfunded, and CN.5 and care for those with chronic conditions.

  The only required core components in the "other" option is a component to conduct quality improvement for the project. We will fulfill this core component in DY5 using milestone 5, Metric P-X.3: Evaluate SNFist implementation, amend as needed before expansion (PDCA). The DY2 Process Milestone (P-X) is to Hire and Utilize a SNFist within the community, specifically nursing homes facilities and within the hospital, with the purpose of improved outcomes for the elderly population. The addition of dedicated physicians to this model will be important to establishing not only a different process for the delivery of care, but also for the time requirements needed to provide face to face care to nursing home patients. The DY3 Improvement Milestone (I-X) will be to increase the number of patients under the care of the SNFis at the designated nursing facility(s). The DY4 Improvement Milestone (I-X) will be for the SNFist to increase the number of patients under his/her care at the designated nursing facility(s). The effectiveness of the project increases with the volume of patients involved. It is out desire to grow the project and include a number of nursing facilities in the effort. DY5's P-X.3 Metric is to evaluate the SNFist implementation, amend it as needed before expansion to other nursing facilities. This will incorporate constant quality improvement into the project. UMC does not currently have a SNFist program and as a result, this is a new initiative for the system. In DY5, Milestone 6 (I-X) will be to increase the number of patients under the care of the SNFis at the designated nursing facility(s).

- **Related Category 3 Outcome Measure(s):**

Outcome Domain: OD-3 Potentially Preventable Re-admissions – 30 Day Readmission Rates
Improvement Target: IT-3.1, 30 day all cause readmission rate.
Nursing home residents account for a sizeable number of our readmissions. Many of these can be avoided – if proactively managed by a SNFist who is on-site…that is the key to this program's success, an on-site MD who can help coordinate care between the nursing facilities and as needed, the acute care hospital. Nursing home populations include Medicare as well as low income, Medicaid patients.

- **Relationship to other Projects:** Redesign primary care relates to 137999206.2.1 Expansion of Chronic Care Management model which focuses on innovation toward improved outcomes. This project will directly relate to this project because by nature, patients in a long-term care facility will have a disproportionately high number of chronic conditions. The SNFists in this project will be a part of the health-care team that works towards addressing the chronic care identified in the other project.
- **Relationship to Other Performing Providers' Projects in the RHP:** N/A
- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to-face meetings, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	A SNFist, located within a nursing home patient's residence, is perfectly situated to address the Triple Aim goals – he or she will help ensure patients receive high-quality, readily available, patient centered care, with the goals of reduced readmissions and avoided admissions (less cost). This model is a revision of the typical healthcare infrastructure by placing the provider within the residence. Medicare and Medicaid patients will benefit from this model. A score of 5 indicates a significant correlation between this model and the goals indicated.	**5**
Addresses Community Need(s)	There are dozens of nursing homes within Lubbock County. Given the aging of the population, more will develop. To redesign primary care…within the nursing facility…ties directly to the needs of the community, not just now but into the future. The dial movement should be most evident in the cost reduced/avoided by carefully considering each potential admission/readmission…and being present on-site to work through social and family dynamics. There is a growing body of evidence to substantiate the efficacy of the SNFist model.	**5**
Project Scope/Size	This project has the potential to re-route a sizeable portion of intervention decisions currently made, regarding hospital transfers. Success in 1 or 2 facilities opens the door for a large impact.	**5**
Project Investment	The investment will be principally in the placement of SNFist(s) within nursing facilities – primary care practitioners with a passion for nursing facility care management and the potential for in-hospital management as well.	**4**

137999206.2.2	2.3.2	N/A	"Other" project option: *Redesign Primary Care*
University Medical Center		**137999206**	
Related Category 3 Outcome Measure(s):	**137999206.3.7**	**IT-3.1**	**All Cause 30 Day Readmission Rate**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-X Utilize SNFist within the community, specifically nursing home facilities and within the hospital, with purpose of improved outcomes for the elderly population: reduced readmissions, and improved on-site care. **Metric: P-X.1** Hire/contract SNFist providers **Baseline/Goal:** There are currently no SNFist providers so the baseline is zero. The goal is to hire/contract with one SNFist to care for patients in 3 nursing home facilities. **Data Source:** Contract of employment or staffing **Estimated Milestone 1 Incentive Payment: $2,427,993**	**Customized Improvement Milestone 3: I-X:** SNFist to increase the number of patients under his/her care at the designated nursing facility(s) **Baseline/Goal:** There are currently no patients under the care of SNFists so the baseline is zero. The goal is to have 28.5% or 100 patients at the designated nursing facilities under the care of the SNFist. **Numerator:** Number of patients cared for by SNFist. **Denominator:** Number of patients within the targeted population. **Data Source:** Patient records **Estimated Milestone 3 Incentive Payment:** $2,648,810	**Customized Improvement Milestone 4: I-X** SNFist to increase the number of patients under his/her care at the designated nursing facility(s) Baseline/Goal: There are currently no patients under the care of SNFists so the baseline is zero. The goal is to have 42.8% or 150 patients at the designated nursing facilities under the care of the SNFist. Numerator: Number of patients cared for by SNFist. Denominator: Number of patients within the the targeted population. **Data Source:** Patient records **Estimated Milestone 3 Incentive Payment:** **$2,656,510**	**Process Milestone 5: P-X** Utilize SNFist within the community, specifically nursing home facilities and within the hospital, with purpose of improved outcomes for the elderly population: reduced readmissions, and improved on-site care. **Metric P-X.3:** Evaluate SNFist implementation, amend as needed before expansion (PDCA) **Baseline/Goal:** There is currently no plan in place for this. The goal is to evaluate the successes and shortcomings of the SNFist program and to change efforts to improve level of success. **Numerator:** Improvements noted **Data Source:** PDCA Analysis **Estimated Milestone 5 Incentive Payment:** **$1,097,254** **Customized Improvement Milestone 6: I-X** SNFist to increase the number of patients

137999206.2.2	2.3.2	N/A	"Other" project option: *Redesign Primary Care*
University Medical Center		**137999206**	
Related Category 3 Outcome Measure(s):	**137999206.3.7**	**IT-3.1**	**All Cause 30 Day Readmission Rate**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
			under his/her care at the designated nursing facility(s) Baseline/Goal: There are currently no patients under the care of SNFists so the baseline is zero. The goal is to have 57% or 150 patients at the designated nursing facilities under the care of the SNFist. Numerator: Number of patients cared for by SNFist. Denominator: Number of patients within the targeted population. **Data Source:** Patient records **Estimated Milestone 3 Incentive Payment:** **$1,097,254**
DY 2 Estimated Milestone Bundle Amount: $2,427,993	DY 3 Estimated Milestone Bundle Amount: $2,648,810	DY4 Estimated Milestone Bundle Amount: $2,656,510	*DY5 Estimated Milestone Bundle Amount: $2,194,508*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,927,821			

Project Option: 2.11.2 Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.2.3

Project Description:
University Medical Center (UMC) proposes to provide medication management for adult diabetes mellitus patients across the continuum of care.

- **Provider:** University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.
- **Interventions(s):** This project will implement a pharmacist-provided medication management program to provide enhanced medication reconciliation, discharge medication counseling, individualized patient education, and post hospital follow-up to reduce medication errors and adverse drug events in adult diabetic patients. Pharmacists will verbally educate on discharge medications, comprehension of medication instructions, and provide written information with patient specific references and learning tools. During the discharge process, pharmacists will also coordinate the filling and delivery of prescriptions to the patient from the UMC Out-patient Pharmacy; if the patient elects to use our out-patient pharmacy.
- **Need for the project:** We currently do not have pharmacists participating in discharge counseling or post hospital follow-up for adult diabetic patients. Diabetes is a complex, increasingly common chronic condition that remains one of the most serious health problems in Lubbock County and Texas. It is the 6th leading cause of death in Texas and approximately 21.9% of adults with diagnosed diabetes do not have health insurance. Lubbock BRFSS data indicate that 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 compared to 26.5/100,000 in Texas. Pharmacist-provided medication management during the critical transition from acute to ambulatory care can result in reductions in physician visits, emergency department visits, hospitals days, patient complications and overall health care costs.
- **Target population:** The target population is all adult diabetic patients admitted to UMC. We anticipate approximately 5,000 adult diabetic patient visits per year with approximately 1,000 being either Medicaid eligible or indigent.
- **Category 1 or 2 expected patient benefits:** This project seeks to increase the number of adult diabetic patients at UMC receiving pharmacist-provided medication management to 20% or about 1,000 patients in DY3, 40% or about 2,000 patients in DY4 and 60% or about 3,000 patients in DY5. We expect a reduction in medication errors and adverse drug events while increasing adherence to an appropriate medication regimen.
- **Category 3 outcomes:** IT-3.3. Our goal is to reduce the diabetes 30 day readmission rate.

Project Option: 2.11.2 Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.2.3
Project Components: 2.11.2 a

Project Description:
University Medical Center (UMC) proposes to provide medication management for adult diabetes mellitus patients across the continuum of care.

Adult diabetes mellitus patients who receive medication management as part of the transition from acute to ambulatory care are more likely to have and adhere to an appropriate medication regimen. This will allow patients to maintain better control of their chronic medical condition and co-morbidities, reduce medication errors and adverse drug events (ADEs), and improve overall health outcomes. Failure to adequately plan and implement medication related transitions from the hospital to home is a cause for failed therapeutic objectives, unplanned visits to the emergency department, and hospital readmissions. UMC will meet all required components except 2.11.2 b which is implementing CPOE. UMC is in the process of implementing CPOE and as a result has already complied with this requirement. UMC proposes to establish a patient-centric medication management program that meets all other required components includes the following:

- Written medication management plan focused on medication safety
- Clearly defined roles for interdisciplinary participants
- Process and criteria to screen for adult diabetic patients
- Standardized medication reconciliation process and counseling by a pharmacist
- Utilization of patient friendly education and medication management tools
- Patient access to outpatient prescriptions on site at UMC Outpatient Pharmacy
- Targeted post-discharge follow up

The intent of the UMC medication management program is to improve medication efficacy and safety in adult diabetes mellitus patients at UMC during the critical transitional phase from acute care to the ambulatory setting. This enhanced medication reconciliation and transitional medication management counseling includes a detailed medication history assessment and reconciliation at admission and discharge. Population-based screening criteria will be used to identify and prioritize adult diabetes mellitus patients for pharmacist intervention during hospitalization. Admission assessment will include a best possible medication history (BPMH) that includes compliance, lack of efficacy, and possible side effects. Adult diabetes mellitus patients will receive individualized patient education, discharge medication counseling and post discharge follow-up. Pharmacists will verbally educate

on discharge medications, comprehension of medication instructions and provide written information with patient specific references and learning tools. During the discharge process, pharmacists will coordinate the filling and delivery of prescriptions to the patient from the UMC out-patient pharmacy; if the patient elects to use our pharmacy (all counseling and education will be completed regardless of whether the patient fills the medications at the UMC out-patient pharmacy). Examples of educational and teaching tools to be used with patients include: an enhanced patient-friendly medication list, patient education leaflets, and MyTeamCare web portal (allows the patient to view their digital health record online). After hospital discharge, the targeted patients will receive a follow-up phone call to reassess comprehension of medications, assess compliance, identify possible ADEs, and address any additional patient concerns. All pharmacy interventions will be recorded in the EHR and significant findings will be communicated to the patient's primary care physician. The continuous quality improvement (CQI) process will consist of quarterly review of data (medication errors, ADEs, pharmacy interventions and patient satisfactions scores) and the sharing of this data and outcomes at our semi-annual regional learning collaborative. There is not a milestone related to the CQI process for this project.

The population for this project will be all adult (age 18 to 75) diabetic mellitus patients admitted at University Medical Center. We anticipate approximately 5,000 adult diabetic patient visits per year with approximately 1,000 being either Medicaid eligible or indigent.

Goals and Relationship to Regional Goals:
The goal of this project is to use pharmacists and pharmacy technicians to target and provide enhanced medication management for all adult diabetes mellitus patients at UMC as they transition from acute care to the ambulatory setting.

Project Goals:

- Reduce medication errors and adverse drug events
- Increase adherence to an appropriate medication regimen
- Provide access to outpatient medications
- Improve patient satisfaction regarding issues and questions about their medications

This project meets the following regional goals:

- Critical/Urgent need – Improves access to care and medications for patients with poor or no insurance support
- Urgent need – Addresses the high incidence of diabetes mellitus in the region
- Urgent need – Provides a specialist to assist in the treatment of diabetes mellitus

Challenges:

The primary challenge for this project will be to engage and educate patients regarding their medication regimen and chronic disease state(s). Diabetes mellitus patients historically have practiced poor medication compliance and lacked an understanding of the severity of their disease state. It will be critical to provide education, collaborate with other services and projects to ensure proper care and follow-up, and provide access to medications for all patients. These challenges can be met by providing extensive interdisciplinary communication, standardized processes, and continual access to a pharmacist for education, questions and/or referrals.

5-Year Expected Outcome for Provider and Patients:
UMC expects to provide pharmacist-provided medication management and counseling to 20% or about 1,000 adult diabetic patients in DY3, 40% or about 2,000 adult diabetic patients in DY4 and 60% or about 3,000 adult diabetic patients in DY5. The provider expects the patients to adhere to an appropriate drug regimen, leading to better control of their chronic condition and an improved quality of life. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
Currently, a pharmacist-provided medication management program does not exist for adult diabetics across the continuum of care. Therefore, the baseline for number of adult diabetics receiving pharmacist provided medication management and counseling begins at 0 in DY2.

Rationale:
Approximately 1.5 million preventable ADEs occur annually as a result of medication errors, at a cost of more than 3 billion per year.[1] One in five patients discharged from hospitals suffers an adverse event, 72% of which are related to medications.[2,3] Seventy-six percent of Medicare readmissions in 2007 were potentially preventable, suggesting that 13 billion of the 15 billion in readmission costs may be unnecessary and preventable.[4] Diabetes is a complex, increasingly common chronic condition that remains one of the most serious health problems in Lubbock County and Texas. Regional patients on survey who were told they have diabetes in 2010 (9.1%) and 2007 (11.0%) were higher compared to nationwide in 2009 (8.3%) and Texas 2007 (9.3%).[5] Statistically there are many more cases of undiagnosed diabetes. Survey respondents indicated that 8.7% were told they had borderline diabetes and 4.3% of women said diabetes was diagnosed when they were pregnant.[5] All national surveys show the incidence of diabetes is increasing. Approximately 1.8 million adult Texans have Type 2 diabetes and 460,000 are undiagnosed.[5] Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause of death for African Americans and Hispanics.[5] Approximately 21.9% of adults with diagnosed diabetes do not have health insurance.[5] Lubbock BRFSS data indicate that 10.7% have diagnosed diabetes.[5] The death rate from diabetes in Lubbock is 38.6/100,000 and is higher than the Texas rate of 26.5/100,000.[5] There is a significant opportunity to address the unmet health care needs of the adult diabetic population in Lubbock County. One study found that a decrease in diabetes medication adherence resulted in 58% increase in hospitalizations and 81% increase in all-cause mortality.[6] The

World Health Organization also estimates that 50% of patients with chronic disease states do not take their medicine as prescribed.[7] Pharmacists are uniquely positioned to help increase medication safety and compliance in patients across the continuum of care. Patients who receive medication management as part of the transition from acute to ambulatory care are more likely adhere to an appropriate medication regimen and receive the right medication at the right time. This enhanced adherence to their medication regime will result in fewer complications for the patient, better outcomes, fewer unplanned emergency department visits, fewer hospital admissions, and provide a cost savings to the health care system. Pharmacist-provided medication therapy review and consultation in various settings resulted in reductions in physician visits, emergency department visits, hospital days, and overall health care costs.[8]

1. Institute of Medicine. Preventing Medication Errors. Washington, DC: The National Academies Press; 2007.
2. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138:161-7.
3. Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital. CMAJ. 2004;170:345-9.
4. Medicare Payment Advisory Commission. Report to the Congress: Promoting Greater Efficiency in Medicare. June 2007. Available at: http://www.med pac.gov/documents/jun07_entirereport.pdf. Accessed July 1, 2011.
5. RHP 12 Needs Assessment Summary
6. Ho PM, Rumsfeld JS,Masoudi FA, et al. Effect of medication nonadherence on hospitalization and mortality among patients with diabetes mellitus. Arch Intern Med. 2006;166(17):1836-1841.
7. World Health Organization. Adherence to long-term therapies: evidence for action [online]. http://www.who.int/chp/knowledge/publications/adherence_report/en/index.html. Accessed December 27,2011.
8. American Pharmacists Association. Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, Version 2.0. March 2008. Available at: http://www.pharmacist.com/MTM/Core Elements2. Accessed July 1, 2011.

The milestones and metrics selected for DY2 focus on developing the medication management program, identifying the target populations and gaining buy-in from those impacted. Building the program off of evidenced based practices and identifying a strong target population for chronic conditions will aid in addressing the care for the chronic conditions identified in the needs assessment. In DY3, DY 4 and DY5 the metrics and milestones are geared towards measuring UMC's success with implementing the program and actually working with patients to manage medications. The goals set are aggressive, but will drive UMC toward a rapid implementation to begin improving the care of patients.

Project Components:
Through the medication management program, we propose to meet all required project components.

a) *Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations.* All adult diabetes mellitus patients will be offered medication management while admitted at UMC. Population based screening criteria will be used to identify and prioritize adult diabetes mellitus patients for pharmacist intervention during their hospitalization. Pharmacists will provide medication management and counseling at the critical time of transition from acute care to the ambulatory setting. These patients will also have access to outpatient medications on site via the UMC Outpatient Pharmacy. After hospital discharge the identified patients will receive a follow up phone calls to reassess comprehension of medications, assess compliance, identify possible adverse drug events, and address any additional patient concerns. All pharmacists' interventions will be recorded in the EHR.

Unique community need identification numbers the project addresses:

- CN.1 – Expense, lack of insurance, access to care
- CN.2 – Lack of insurance, need to use ERs for initial contact
- CN.3 – Poor insurance support or uninsured
- CN.4 – High incidence of diabetes mellitus
- CN.5 – Need for specialists to assist in the treatment of diabetes mellitus

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, a pharmacist-provided medication management and counseling program does not exist for adult diabetes mellitus patients at University Medical Center. UMC currently offers electronic physician medication reconciliation and nurse discharge instructions. This program will enhance the medication reconciliation process, initiate pharmacist-provided medication counseling, provide targeted discharge follow-up, and proved access to discharge outpatient prescriptions on site at the UMC Outpatient Pharmacy.

Related Category 3 Outcome Measure(s):
OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
IT-3.3 Diabetes 30 day readmission rate

Reasons/rationale for selecting the outcome measures:
Diabetes mellitus is a pervasive disease among the population of patients we serve. Improved understanding of medication use and closer monitoring of patient compliance should reduce the incidence of morbidities and negative outcomes, including patient readmissions. To date we have no specific information on the size of the adult diabetic population seen at UMC, the understanding

of medication use related to diabetes, or the compliance with a prescribed drug regimen among diabetic adults. However, historically diabetic patients have had poor medication compliance and lack an understanding of the severity of their disease state and co-morbidities. The mortality rate from diabetes in Lubbock is 38.6/100,000 compared to 26.5/100,000 in Texas. In addition, we have not studied the readmission rate for this population of patients. Therefore we would propose collecting and reviewing data during DY-2 to ensure that we understand the size and scope of the problem so that appropriate interventions can be devised and implemented in DY-3. The improvement targets will be established after collecting and reviewing data on the existing conditions. This will allow us to estimate the potential opportunity for improvement more precisely than we would be able to do without having the appropriate data on hand.

Relationship to other Projects:

This project's focus on identifying adult diabetics, education, access to a healthcare provider and medications, and support across the continuum of care ties to several projects in our plan. The medication management is a resource for other projects focused on care of patients with chronic conditions including 137999206.1.1 Implement a chronic disease management registry and 137999206.2.1 Expand chronic care management models. Assuring that patients with chronic conditions are discharged from the acute care setting with a more complete understanding of the medications they are using are more likely to remain on the medication regimen. This will have a positive impact on the overall well-being of the chronic patient. Additionally, medication management is a critical component of the care of patients in a long-term care setting such as those in the target population in 137999206.2.2 Redesign of primary care.

Relationship to Other Performing Providers' Projects and plan for learning collaborative:

Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	The incidence of diabetes mellitus has increased tremendously in the US population and is more prominent in minority and poor communities where a lack of access to healthcare contributes incrementally to the overall problem. Numerous studies have shown that improved understanding of drugs and their use in controlling the disease and improving lifestyle and survivability along with ongoing monitoring and contact with healthcare professionals will reduce the negative outcomes associated with this disease. This project will combine the benefits of improved medication knowledge/compliance with access to and monitoring by a healthcare professional in an effort to improve patient outcomes and reduce diabetic readmissions to the hospital.	**5**
Addresses Community Need(s)	Diabetes Mellitus – Patients on survey who were told they have diabetes in 2010 (9.1%) and 2007 (11.0%) are compared to nationwide in 2009 (8.3%) and Texas 2007 (9.3%). Statistically there are many more cases of undiagnosed diabetes. Survey respondents indicated that 8.7 were told they had borderline diabetes and 4.3% of women said diabetes was diagnosed when they were pregnant. All national surveys show the incidence of diabetes is increasing. Approximately 1.8 million adult Texans have Type 2 diabetes and 460,000 are undiagnosed. Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause of death for African Americans and Hispanics. Approximately 21.9% of adults with diagnosed diabetes do not have health insurance. Lubbock BRFSS data indicate that 10.7 percent have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 and is higher that the Texas rate of 26.5/100,000.	**5**
Project Scope/Size	It is estimated that approximately 10% of the populations suffers from diabetes mellitus. This results in a large number of hospitalizations, amputations, kidney failure, heart disease, infections, and mortality. This project will reduce the number of diabetic hospitalizations by improving medication knowledge and compliance and providing better access to healthcare providers. UMC will hire additional pharmacist staff to make contact with patients prior to discharge and then follow up regularly to monitor compliance and complications and make recommendations for primary physician contact if necessary to avoid situations from developing to the point of requiring hospitalization. Potential savings are significant, especially in the long-term, when one considers the cost of dialysis, renal transplant, sepsis, and other very serious complications of diabetes.	**4**
Project Investment	The major investment in implementing this project consists of hiring pharmacists and support staff to carry out this new function and monitor the results. The exact number of staff will be determined after data collection is accomplished and the number of patients to be followed is known.	**3**

137999206.2.3	2.11.2	2.11.2.a	Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.
University Medical Center			137999206

Related Category 3 Outcome Measure(s)	137999206.3.8	IT 3.3	Diabetes 30 day readmission rate
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Milestone 1: [2.11 P-2] Develop criteria and identify targeted patient populations Metric 1: [2.11 P-2.2] Written medication management plan(s) Goal: Identify and provide medication management counseling to adult diabetic patients admitted to University Medical Center. UMC anticipates approximately 5,000 adult diabetic patient visits per year with about 1,000 being either Medicaid eligible or indigent Data Source: Paper or electronic health record Estimated Milestone 1 Incentive Payment:$1,213,996 Milestone 2: [2.11 P-4] Implement an evidence based program based on best practices for medication reconciliation to improve medication management and continuity between acute care and ambulatory setting Metric 1: [2.11 P-4.1] Written plan to	Milestone 3: [2.11 I-9] Manage medications for targeted patients Metric 1: [2.11 I-9] Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management Baseline/Goal: 20% or about 1,000 of adult diabetic patients receive pharmacist-provided medication management and counseling Data Source: Paper or electronic health record Estimated Milestone 2 Incentive Payment: $2,648,810	Milestone 4: [2.11 I-9] Manage medications for targeted patients Metric 1: [2.11 I-9] Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management Baseline/Goal: 40% or about 2,000 of adult diabetic patients receive pharmacist-provided medication management and counseling Data Source: Paper or electronic health record Estimated Milestone 5 Incentive Payment: $2,656,510	Milestone 5: [2.11 I-9] Manage medications for targeted patients Metric 1: [2.11 I-9] Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management Baseline/Goal: 60% or about 3,000 of adult diabetic patients receive pharmacist-provided medication management and counseling Data Source: Paper or electronic health record Estimated Milestone 5 Incentive Payment: $2,194,508

provide medication reconciliation as part of the transition from acute care to ambulatory care Goal: Pharmacist –provided medication management for adult diabetic patients Data Source: Medication Management Plan Estimated Milestone 2 Incentive Payment: $1,213,997			
DY 2 Estimated Milestone Bundle Amount: $2,427,993	DY 3 Estimated Milestone Bundle Amount: $2,648,810	DY4 Estimated Milestone Bundle Amount: $2,656,510	*DY5 Estimated Milestone Bundle Amount: $2,194,508*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,927,821			

Project Option: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider Name/TPI: University Medical Center/137999206
Unique Project ID: 137999206.2.4 – **"PASS 2"**

Project Description:

- **Provider:** University Medical Center, a major teaching hospital and the regions only Level 1 trauma center, is a 438 bed hospital serving over 1 million people in West Texas and Eastern New Mexico.
- **Interventions(s):** This project will be to transition to a team-based approach to end of life care utilizing a group of board certified palliative care physicians. The team will hold family conferences to assist patients and families in the selection of appropriate goals of care based on the individual prognosis for each patient. The project will include education of patients about their individual prognosis and potentially in transitions to Hospice programs where appropriate. A specialized, palliative care, inpatient unit will be launched with an expert team that can manage critically ill patients who elect to move toward supportive care and hospice with experienced nurses who are trained in the skills of end of life nursing care.
- **Need for the project:** Patients should receive dignified and culturally appropriate care to relieve suffering in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences. As the public hospital for the region, UMC sees a disproportionately large number of patients who are under- or uninsured, non-English speaking, or of lower socioeconomic statuses, who often present with more advanced illness and have fewer treatment options. Of those treated at UMC, over 20% of the total population is Medicaid and almost 15% of the population is unfunded. For these reasons, we see a large number of patients with a high symptom burden and poor prognosis. It has been demonstrated that palliative care teams in hospitals improve multiple outcomes including both clinical and financial.
- **Target population:** The population for this project will be chronically and severely ill patients that are seen by the palliative care team in University Medical Center. Our baseline palliative care consult number is 285. We anticipate increasing this to 570 annual consults with the enhanced palliative care program. Over 20% of the patients treated at UMC are on Medicaid and another 15% of the total patients have no source for funding.
- **Category 1 or 2 expected patient benefits:** The overall goal of the project is to expand the capacity and function of an existing nurse led palliative care team into one that includes board certified physicians to better serve the patient population. Specifically, in DY3 we plan to increased palliative care consults by 40% or 115 new consults. In DY4 we plan to increase palliative care consults by 75% increase over baseline or 215 consults, Screen 80% or 400 of our consults for dyspnea and increase the number of in-hospital deaths who had a palliative care consult. By DY5 we anticipate palliative care consults to be 100% over baseline or 570 palliative care consults, treat 50% of patients screened positive for dyspnea within 24 hours,

increase the number of in-hospital deaths who had a palliative care consult and implement a patient /family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care.

- **Category 3 outcomes:** IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)- Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.

Project Option Title: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider: University Medical Center - 137999206
Unique RHP Project ID: 137999206.2.4 – **"PASS 2"**
Core Components: 2.10.1.a-d

Project Description: Expand the use of palliative care services in Lubbock County. This will be a team-based approach to care at the end of life. Currently a physician from the Internal Medicine Department is available for consultations part-time with a nurse provided from the hospital for palliative care consultations. We will be hiring a Palliative Care Director who is board-certified in hospice and palliative medicine who will be tasked specifically with developing a team in the hospital to improve processes in end-of-life care and increase the number of patients to which this care is provided. As part of this he will manage a team of physicians who are all board certified and will bring expert skills in management of pain and other symptoms for patients as the end of life nears. To help care for children with critical or end of life illness, this team will also include a pediatric intensive care specialist who is also board certified in hospice and palliative care This team will also hold family conferences to assist patients and families in the selection of appropriate goals of care based on the individual prognosis for each patient. Excellent communication and clear guidance about options is the cornerstone of these goals of care meetings. This process is expected to educate patients about their individual prognosis and potentially assist in transitions to Hospice programs where appropriate. The team will also be responsible for expert symptom management at end of life. Specifically, the team will improve care of dyspnea at end of life. The team's capacity to see more patients will also be augmented by adding a physician to the team as well as other practitioners and specialists. The population for this project will be chronically and severely ill patients that are seen by the palliative care team in University Medical Center. This population includes under insured and uninsured patients whose end of life care needs have not traditionally been met.

The team will also include assistance from chaplains, social workers, nursing and other staff members as needed. This multidisciplinary team will bring expert care to address all domains of suffering as described in the Saunders model of hospice and palliative care. This type of care has been shown to be cost efficient and result in high patient and family satisfaction. The needs of these patients are often very complex and a team of professionals, each expert in their own area is key to successful interventions.

To assist in the difficult transitions of care from curative to hospice a specialized, palliative care, inpatient unit will be launched. This unit will be helpful in making transitions from high intensity and cost ICU care to high compassion and low cost hospice care. In this

specialized unit, the expert team can then manage critically ill patients who elect to move toward supportive care and hospice with a cadre of experienced nurses who are trained in the skills of end of life nursing care.

In order to identify patients who are nearing the end of life a screening process will be conducted on those patients who are in the ICUs as often these critically ill patients may meet the criteria for palliative care intervention. The leadership group will trend this data and screen other groups as indicated. Another area of potential screening is the emergency room and as the program grows this group will be targeted for screening as well.

- **Goal:** The overall goal of the project is to expand the capacity and function of an existing nurse led palliative care team into one that includes board certified physicians to better serve the patient population at University Medical Center. Specifically, within five years the palliative care service will see more patients and provide more effective outcomes related to severely ill patients. With the addition of physician, the team will have more capacity to see patients and this will achieve our goal of increasing the number of palliative care consults. In addition more patients will have an effective goals of care conversation leading to more conversions to hospice care for the chronically and severely ill patients seen by the team. This will ultimately lead to reduced costs for this group of severely ill patients.

- **Relationship to Regional Goals:** The regions primary goals are to be responsive to the issues identified in the community needs assessment and to achieve progress towards the triple aim goals of improving the patient experience including quality and satisfaction, improving the health of populations and reducing the per capita cost of care. This project will contribute towards improving the quality and satisfaction of the patient by proving the right approach to care in a timelier manner. Studies have shown that palliative care services improve patients' symptoms, allow patients to avoid hospitalization and to remain safely and adequately cared for at home, lead to better patient and family satisfaction, and significantly reduced prolonged grief and posttraumatic stress disorder among bereaved family members. This project will build a multidisciplinary palliative care team that will care for patients within our health system including under-insured and uninsured patients who suffer from chronic conditions such as obesity, diabetes mellitus, heart disease, asthma, chronic lung disease, and cancer. As these illnesses progress, the symptom burden grows and palliative care treatments are needed to ease this suffering. This project seeks to meet these needs that have previously been inadequately addressed. The team has identified improvement goals that incorporate come symptoms in these chronic illnesses.

- **Challenges:** The most difficult challenge to implementation of an effective palliative care program is acceptance by treating physicians and acceptance of family members. The perception of palliative care is that it is an admission of failure by the physician and the family perceives that there is no hope left for the patient. This project will move the palliative care approach forward by incorporating physician-to-physician education about the benefits of the palliative care approach. Further, patients and families will receive education and guidance on the benefits of palliative care in the treatment of the patient.

Starting Point/Baseline: Our baseline of 285 patients seen by palliative care team lead by nurse manager with minimal physician input as needed. The small, nurse led process provided consultation only services on a limited number of patients. Availability was on weekdays only. The new process will provide coverage around the clock for all seven days per week. This staffing model better accommodates the initial high acuity of these patients. Involving physicians who are expert in having these emotionally charged, high stakes goals of care discussions is a key element in the new, strengthened approach to palliative care. These same doctors also add skills in management of difficult symptoms for these patients as well.

Rationale: The primary goal of this project is to enhance end of life care for patients in Lubbock County to better accommodate the needs of the patient population, families, and community. Patients should receive dignified and culturally appropriate care to relieve suffering in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences. As the public hospital for the region, UMC sees a disproportionately large number of patients who are under- or uninsured, non-English speaking, or of lower socioeconomic statuses, who often present with more advanced illness and have fewer treatment options. Of those treated at UMC, over 20% of the total population is Medicaid and almost 15% of the population is unfunded. For these reasons, we see a large number of patients with a high symptom burden and poor prognosis.

It has been demonstrated that palliative care teams in hospitals improve multiple outcomes including both clinical and financial. There is an emerging literature that palliative care teams improve patient and family satisfaction with care at the end of life. Specifically, palliative care teams can assist with pain and symptom management, recognition of the patient as a whole person, clear medical decision-making, life completion and preparation for death. Palliative care consultations have been clearly associated with decreased costs of care at the end of life and higher quality of life in the week before death. Palliative care teams are instrumental in assisting with transitions in care such as transfers out of the ICU when critical care is no longer effective or consistent with patients' goals, or to hospice when further disease-focused treatments are not available or helpful. Conversations about preferences for end-of-life care have been shown to improve quality of life for patients and caregiver bereavement. Additionally, palliative care can and should be provided to any patient with suffering, regardless of their prognosis or options for life-prolonging treatments. The project

dramatically augments our existing nurse led palliative care service by adding board certified physicians to the team. This will increase both the scope of end of life skills offered to our patients and the capacity to see more patients with palliative needs. In addition having a physician lead a goals of care discussion will result in more conversion of end of life patients to the lower cost option of hospice, thus producing savings overall for this population of patients.

Project Components:

- Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program. This component is not included in this plan. University Medical Center has already performed this component and initiated the framework for the palliative care program.
- Through the use of goals of care discussions with patients and families the palliative care team will discuss prognosis and options for care that helps to transition patients from acute hospital care into home care, hospice or a skilled nursing facility. The key element of a goals-of-care discussion is to make sure the patient/ family understand the severity of illness, the prognosis, and be presented with alternative to high intensity care that may not be wanted or needed. The interdisciplinary team includes social workers that will help to facilitate these arrangements.
- In order to continually improve, the team will Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care. These surveys will be sent to every patient/family who receive care from the team. Results will be reviewed quarterly to improve the function of the team. Results will be shared with each member of the team and after initial benchmarking we will use a programmatic approach (i.e Press-Ganey) to drive performance higher.

As the program develops there will be a need to continually improve the program. To accomplish this, the group will conduct on-going quality improvement using methods such as rapid cycle improvement. In this process a measure is selected and the data analyzed. An aim statement is formulated to drive the improvement and a plan devised to improve the given metric. The plan is launched and evaluated. From the evaluation the intervention is either adopted if successful or further modified to achieve the desired result. As we launch the new program our first improvement effort will focus on improving patients identified in the ICU who through a goals of care discussion are converted from acute care to hospice. Target areas will include conditions within the ICU setting where frequent palliative care needs are identified such as recurrent admissions in COPD, Heart Failure, Dementia and Cancer patients.

Unique community need identification numbers the project addresses:

- CN.3 - Poor insurance support or uninsured
- CN.5 - Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease and other chronic conditions. Travel to Urban areas for care is difficult.

Related Category 3 Outcome Measure(s): IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)- Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.285 ***(****Standalone measure)*

This measure was selected because patients at the end of life often seek care in the emergency room setting. Such care is often very expensive. The care in many cases could be provided in the home through hospice at much less cost and with better patient/family satisfaction. Our interventions should address this rate very effectively and achieve the triple aim goals well.

Relationship to other Projects: This project supports the reduction in unnecessary admissions and readmissions. By providing more patient centered care with transition to involvement of hospice the patients receive the appropriate palliative care at home instead of undergoing a costly admission. Patient satisfaction is enhanced because patients do not undergo uncomfortable admissions and can stay within their own home while receiving high quality care. This ties to the following project:

- 137999206.2.2 – Redesign Primary Care – SNF

Relationship to Other Performing Providers' Projects in the RHP: Similar to Covenant Health System palliative care project focuses on the transition of care from the inpatient palliative care setting to outpatient. While these projects are similar, they focus on separate populations.

Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.

Project Valuation:

Criteria	Narrative	Score (1-5)

Achieves Waiver Goals	This palliative care intervention greatly helps to further the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. Most patients prefer to die at home however most patients die in the hospital because they did not have access to high quality palliative care programs. This project will serve the Medicaid and uninsured residents of our county since the operation will be within the county hospital where a majority of these patients seek their care. Palliative care will serve as a liaison with medical staff in transitioning patients into cost effective hospice systems. Numerous studies have shown that Palliative care will Improve outcomes while containing cost growth by reducing unnecessary admissions and readmissions.	**4**
Addresses Community Need(s)	Our community needs patient centered care at the end of life. Currently there is limited access to high quality palliative care with certain sub-populations. Within the county hospital patients who have Medicaid or underinsurance are frequently faced with critical illness or end of life issues. As this facility serves as the safety net hospital for the region it is critical that high quality palliative care programs exist to meet this nee	**3**
Project Scope/Size	In the end everyone faces death and it is critical that patients receive high quality end of life care. This is true regardless of the economic class or ethnic background. While death is ubiquitous each person is unique. It is critical that each persons end of life care is centered on their unique needs. In this way the various cultures and ethnic groups can receive culturally appropriate care at such an important time as critical illness and end of life.	**3**
Project Investment	The major capital needed to deliver high quality care is the time of the professionals who will be working with the patients and their families to deliver this care. As might be expected this can be considerable as families grapple with the very difficult decisions regarding their loved ones. Palliative medicine is a multi-disciplinary field and practitioners from across medicine will have to be engaged. From social workers to chaplains to nurse managers to physicians all are integral to an effective team. Another important need for excellent care is the need to create a strong culture across the health system to support palliative care. This requires education and active programing. These systems will require development and on-going maintenance.	**3**

137999206.2.4	*2.10.1*	*2.10.1.A-D*	**Implement a Palliative Care Program to address patients with end-of-life decisions and care needs**
University Medical Center			***137999206***
Related Category 3 Outcome Measure(s):	***137999206.3.9***	***3.IT-13.3***	**Proportion with more than one emergency room visit in the last days of life**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P-3 Implement palliative care education and training programs for providers (physicians, RNs, PAs, NPs, etc.) that incorporates management of non-cancer patients. **Metric 1 - P-3.1** Palliative care training and education for other providers **Baseline/Goal:** Formal education and training does not currently exist. Goal is to train 20 providers including physicians, NPs, RNs and PAs. **Data Source:** Database that tracks type and number of training and education sessions by health professional category (physicians, RNs,PAs, NPs, etc). Milestone 1 Estimated Incentive Payment: $1,104,640 **Milestone 2 – P-5** Expand a palliative care program **Metric 1 - P-5.1**	**Milestone 3** [P-6]: Increase the number of palliative care consults **Metric 1 [P-6.1]:** Palliative care consults meet targets established by the program **Baseline/Goal:** Projected 400 consults during DY3 to current nurse-led program. Goal is an increase of number of consults by 40% or 115 new consults from current consult level and for the consults to be in the new enhanced program. **Data Source:** EHR, palliative care database **Milestone 3 Estimated Incentive Payment:** $1,153,635 **Milestone 4 [P-8]:** Document the conditions for which palliative care is consulted. **Metric 1 [P-8.1]:** Breadth of conditions for which palliative care is utilized.	**Milestone 5** [P-6]: Increase the number of palliative care consults **Metric 1 [P-6.1]:** Palliative care consults meet targets established by the program **Baseline/Goal:** Projected 500 consults during DY4 to current nurse-led program. Goal is an increase of the number of consults by 75% or 215 new consults from current consult level and for the consults to be in the new enhanced program. **Data Source:** EHR, palliative care database **Milestone 5 Estimated Incentive Payment:** 734,017 **Milestone 6: I-10** Among patients who died in the hospital, increase the proportion of those who received a palliative care consult **I-10.1. Metric:** Percent of total in-hospital deaths who had a palliative care consult	**Milestone 8** [P-6]: Increase the number of palliative care consults **Metric 1 [P-6.1]:** Palliative care consults meet targets established by the program **Baseline/Goal:** Projected 570 consults during DY5 to current nurse-led program. Goal is an increase of the number of consults by 100% or 285 new consults from baseline consult level and for the consults to be in the new enhanced program. **Data Source:** EHR, palliative care database **Milestone 8 Estimated Incentive Payment:** $437,229 **I-11. Milestone 9:** Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care **I-11.4. Metric:** Dyspnea treatment (NQF-1638) - Percentage of patients who screened positive for dyspnea

137999206.2.4	*2.10.1*	*2.10.1.A-D*	**Implement a Palliative Care Program to address patients with end-of-life decisions and care needs**	
		University Medical Center		***137999206***
Related Category 3 Outcome Measure(s):	***137999206.3.9***	***3.IT-13.3***	**Proportion with more than one emergency room visit in the last days of life**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Implement comprehensive palliative care program **Baseline/Goal:** Current program is a nurse-led effort. Goal is to implement a formal program led by a board-certified physician. **Data Source:** Palliative care program documentation. **Milestone 2 Estimated Incentive Payment:** $1,104,640	**Baseline/Goal:** Documentation does not currently exist. Goal is to have complete documentation of conditions for consultation. **Data Source:** EHR, palliative care database **Milestone 4 Estimated Incentive Payment:** $1,153,634		**Goal:** In 2012 our hospital had 529 deaths. We are working on determining baseline. **Data Source:** EMR **Milestone 6 Estimated Incentive Payment:** $ 734,017 **I-11. Milestone 7:** Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care **I-11.3. Metric:** Dyspnea screening (NQF-1639) - Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation or palliative care initial encounter. **Goal:** Our goal is to screen 80% or 400 palliative care patients for dyspnea on their initial encounter Data Source: EMR, Palliative care logs **Milestone 7 Estimated Incentive Payment:** $ 734,017	who received treatment within 24 hours of screening. **Goal:** Our goal is to treat 50% of patients screened positive for dyspnea within 24 hours. Our baseline will be established from our numbers in DY4. **Data Source:** EMR & palliative care logs **Milestone 9 Estimated Incentive Payment:** $437,229 **Milestone 10: I-10** Among patients who died in the hospital, increase the proportion of those who received a palliative care consult **I-10.1. Metric:** Percent of total in-hospital deaths who had a palliative care consult **Goal:** In 2012 our hospital had 529 deaths. We are working on determining baseline. Data Source: EMR **Milestone 6 Estimated Incentive**

137999206.2.4	*2.10.1*	*2.10.1.A-D*	**Implement a Palliative Care Program to address patients with end-of-life decisions and care needs**
University Medical Center			*137999206*
Related Category 3 Outcome Measure(s):	*137999206.3.9*	*3.IT-13.3*	**Proportion with more than one emergency room visit in the last days of life**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			Payment: $437,229 **Milestone 11 [I-12]:** Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care. **Metric 1 [I-12.1]:** Survey developed and implemented over time Scores increased over time **Baseline/Goal:** No survey currently exists. Goal is to implement a survey and work to increase scores over time . **Data Source:** Documentation of implemented survey **Milestone 11 Estimated Incentive Payment:** $437,229
Year 2 Estimated Milestone Bundle Amount: $2,209,280	**Year 3 Estimated Milestone Bundle Amount:** $2,307,269	**Year 4 Estimated Milestone Bundle Amount:** $2,202,052	**Year 5 Estimated Milestone Bundle Amount:** $1,748,916
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,467,517			

Project Option 2.15.1 Summary: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Performing Provider: West Texas Centers/130725806
Unique Identification Number: 130725806.2.1

Provider: West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health for the established service area through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in eight counties in the RHP 12 area. We are the primary and often the only behavioral health care provider in most if not all of the counties we serve in RHP 12.
Intervention: This is an integration project between a primary care provider and WTC in Lamesa, Texas.
WTC currently operates a mental health clinic in Lamesa employing about five staff on site with approximately four more providing itinerant and telemedicine services. Interest has been expressed for an integrated site by the local hospital and it is anticipated they will become the community partner. This integration will involve WTC moving to a co-located site with the primary care provider and a gradual collaboration to include cross training, consultation and sharing of space and potentially support and nursing staff. This endeavor is the first of its kind for West Texas Centers as well as for Lamesa and Dawson County and will provide a level of care not normally present in such a rural area.
Need for the Project: West Texas Centers currently serves approximately 138 persons annually in Dawson County, with about eighty nine of these persons seen on a monthly or quarterly basis. Additionally WTC responds to approximately 140 behavioral health crisis calls annually in Dawson County. In an area with little public transportation and an ongoing shortage of all types of providers an integration of primary and behavioral health care will improve access to both types of services by the full population of the County. This project addresses RHP 12 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lock of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP. This project represents a new initiative for West Texas Centers as well as the RHP. WTC's integrated care project tremendously supports the regions goals of right care, right setting and right time treatment for behavioral health consumers.
Target Population: The project will provide an enhanced level of services to the West Texas Centers priority population as defined by the Department of State Health Services and includes those persons under 200% of poverty, anticipated to be 44% Medicaid and 54% indigent with severe and persistent mental illness.
Category 2 expected patient benefits: Improvement milestones were selected exactly from the protocol with implementation of I-8(Cat 2 pg 324), by DY 4 which will see 80% or 110 patients served by WTC at the integrated location site receiving both physical and

behavioral health care. This number will increase to 100% or approximately 138 patients in DY 5. Improvement Milestone I-9(Cat 2, pg 324) individuals with a treatment plan developed and implemented with primary care and behavioral health expertise was also selected. In DY 4 WTC expects to have a minimum of 20% or 21 persons having a treatment plan with involvement by both behavioral health and the primary care provider. This number will increase to 30% or 41 patients by DY 5. It is expected the integrated model will accommodate additional persons as ongoing process and service improvements occur which could potentially increase these projections substantially; however since there is currently no similar behavioral health and primary health care integration occurring in this county it is difficult to identify exact patient transition and timeframes from the current model.
Category 3 outcomes: West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems being selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This would equate to 34 persons indicating improved patient satisfaction due to the integrated service provision. Subsequently in DY 5 this expectation was increased to 40% or 55 persons indicating improved patient satisfaction due to the integration of services. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

Project Option: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Project Title: West Texas Centers Dawson County Behavioral and Primary Care Integration Project
Performing Provider: West Texas Centers/130725806
Unique Identification Number: 130725806.2.1
Project Components: 2.15.1.A-J

Project/Intervention Title: West Texas Centers Dawson County Co-Location/Integration Project
Project Description: West Texas Centers will develop a behavioral health and primary care integrated project in Lamesa, Texas located in Dawson County. Dawson County is a designated health Professional Shortage Area (HPSA) located approximately sixty miles from a major primary health care facility. It is anticipated, but not yet determined that West Texas Centers will expand service capacity to facilitate integration with the physical health population of the community through a collaborative lease agreement with Medical Arts Hospital located at 2200 North Bryan. The project will provide onsite access to behavioral health care while facilitating more opportunities to address both the physical and mental needs of the consumer. Current integration with primary health care is limited to "crisis events" and limited coordination with PCP providers when patient needs overlap. Specific improvement targets, as discussed in the valuation section of this document, will see a minimum of 110 individuals being served under the integrated care model receiving both primary and behavioral health care services at this site. In DY 5 it is projected this number will increase to a 100% or approximately 138 patients receiving both primary and behavioral health care services. In addition in DY 4 a minimum of 20% or 27 of the 138 average number of WTC patients receiving services at the integrated location will have treatment plans developed and implemented with primary care and behavioral expertise indicated annually with that number increasing to 40% or 41 persons by DY 5.**Project Goals:** West Texas Centers currently operates a mental health clinic in Dawson County separate from the Primary Care Clinic and Medical Arts Hospital. At the present time the Center has no co-location of Center services with primary care in the total twenty three county areas the Center serves. Research indicates persons with mental health issues average age at death is much lower than the general population. Mental Health consumers continue to deal with the stigma of mental illness and are reluctant to see primary care in a public type setting. Based on this research and the enthusiasm of the Dawson County primary care community related to development of an integrated site, the environment for such a project seems to virtually insure success. Based upon preliminary review of WTC crisis data related to Dawson Count diversion from the emergency department and from potential incarceration/law enforcement involvement should occur more naturally and more effectively through the integrated arrangement. Through the integration of behavioral health and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Dawson County has

limited public transportation. This project will enhance access to care as individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs. Given the ever-increasing cost of transportation, a "one stop shopping" approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions. Research supports co-location alone is not synonymous with integration. Levels of interaction between physical and behavioral health providers may range from traditional minimally collaborative models to fully integrated collaborative models. This project will result in behavioral health providers sharing the same facility, having some systems in common, participating in regular face-to-face communication and functioning with primary care providers in team approaches to patient care. This will be the first such integration project in the community related to behavioral health and primary care.

Project Challenges: Expected challenges will involve the continued difficulty rural providers have in recruiting and retaining qualified professional staff. Additionally, the rural nature of the community and lack of any public transportation will continue to present significant difficulties for consumers. As with any integration of historically separate systems, staff and consumer's resistance to change will require processes to be well communicated and carefully implemented. WTC's excellent community relationships and already established community partners should provide an effective basis to meet these challenges.

Five Year Expected Outcome: The expected outcome by the end of demonstration year 5 is to have developed a close collaboration environment in a co-housed facility with a primary health provider in Dawson County. The project will result in behavioral health and primary care provider's interacting in regular face-to-face communication, identifying training needs, providing a "pool" of professionals with differing expertise while addressing multiple needs of the consumer. Other expected outcomes include increased diversion from the emergency department of the local hospital, better coordination of shared patients primary and behavioral care appointment scheduling, thus reducing some transportation needs and increased community behavioral health education opportunities. Patient benefit as discussed in the valuation section of this document will see in DY 4 a minimum of 110 individuals being served under the integrated care model receiving both primary and behavioral health care services at this site. In DY 5 it is projected this number will increase to a 100% or approximately 138 patients receiving both primary and behavioral health care services. In addition in DY 4 a minimum of 20% or 27 of the 138 average number of WTC patients receiving services at the integrated location will have treatment plans developed and implemented with primary care and behavioral expertise indicated annually with that number increasing to 40% or 41 persons by DY 5.

Continuous Quality Improvement: West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to

provide real time program resolution.CQI activities will include input, communication and coordination with primary care providers at the site.

Relationship to Regional Goals: This project will continue the regional effort to transform health care delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Starting Point/Baseline: Baseline encounter data will be obtained from WTC fiscal year 2012 records to include unduplicated monthly Dawson County mental health consumers served as well as other data relevant to this project. WTC will continue to refine baseline data during DY 2 as West Texas Centers currently has no co-located facility serving both behavioral health and primary care, therefore much of the baseline data will come from DY 3 data.

Core Components: West Texas Centers will complete all core components of this project. Those components are: a) identify sites for integrated care projects, which would have the potential to benefit a significant number of parties in the community; b: develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated; c) establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers; d)recruit a number of specialty providers(physical health, mental health, substance abuse, etc. to provide services in the specified locations; e) train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include; regular consultative meetings between physical health and behavioral health practitioners; case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or shared treatment plans co-developed by both physical health and behavioral health practitioners; f) acquire data reporting, communication and collection tools(equipment) to be used in the integrated setting, which may include an integrated EHR record system or participation in a health information exchange; g) explore the need for and develop any necessary legal agreement that may be needed in a collaborative practice; h) arrange for utilities and building services for these settings; i) develop and implement data collection and reporting mechanisms and standards to track utilization of integrated services as well as the health care outcomes of individuals treated in these integrated service settings; j) conduct quality improvement for project using methods such as rapid cycle improvement. Measures and metrics were selected to include completion of these core components. Activities may include, but are not limited to identifying project impacts, identifying lessons learned, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. West Texas Centers has thoroughly reviewed these core components and developed strategies associated with each. Strategies include utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments,

procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring. West Texas Centers will achieve completion of all core components, milestones and metrics of the project within the established timeframes.

Rationale: This project addresses RHP 12 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP. This project represents a new initiative for West Texas Centers as well as the RHP. Dawson County currently has providers in separate facilities with only limited interaction. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied. The integration of behavioral health and primary care logically improve the opportunities to better meet the needs of the consumer while lowering costs through economies of scale all of which are RHP goals and were identified in the community needs assessment. The integrated model will also demonstrate a progressive, evidenced based approach to health care essential to the recruitment and retention of highly qualified professionals, particularly in rural communities. The importance of this project to the local community in Dawson County cannot be overstated. West Texas Centers recognizes the importance of achieving all required core components of this project and anticipates all components, milestones and metrics will be achieved within the 5 year demonstration period.

Milestones and Metrics:

Process milestones were selected to identify and determine the exact primary care provider, location and facility for the project. Additionally analysis will occur related to each of these decisions. The project will provide an enhanced level of services to the West Texas Centers priority population as defined by the Department of State Health Services and includes those persons under 200% of poverty, anticipated to be 44% Medicaid and 54% indigent with severe and persistent mental illness. Since this will be West Texas Center's first integrated location, the process milestones will determine the ultimate project baseline as well as set the foundation for the improvement milestones associated with actual integration of services with collaboration between behavioral health providers and primary care related to treatment planning, team consultations and some shared scheduling. WTC developed a custom milestone P-X-1 for Milestone 3 to identify the final decision on the location of the project and to capture the process of initiating all facility agreements to include leases, renovation plans and other documents essential to be completed in DY 3. Improvement milestones selected are directly related to West Texas Centers and the Primary Care provider's level of service integration. Improvement milestones selected will insure at a minimum West Texas Centers will achieve a level four integration (per the Category 2.15(Cat 2, pg 317-318) project goals in the protocol) where providers share the same facility and have some systems in common such as scheduling appointments or medical records, have regular communication and have a sense of being part of a

team. Improvement milestones were selected exactly from the protocol with implementation of I-8(Cat 2 pg 324), by DY 4 which will see 80% or 110 patients served by WTC at the integrated location site receiving both physical and behavioral health care. This number will increase to 100% in DY 5. Improvement Milestone I-9(Cat 2, pg 324) individuals with a treatment plan developed and implemented with primary care and behavioral health expertise was also selected. In DY 4 WTC expects to have a minimum of 20% or 21 persons having a treatment plan with involvement by both behavioral health and the primary care provider. This number will increase to 30% or 41 patients by DY 5. It is expected the integrated model will accommodate additional persons as ongoing process and service improvements occur which could potentially increase these projections substantially; however since there is currently no similar behavioral health and primary health care integration occurring in this county it is difficult to identify exact patient transition and timeframes from the current model.

Related Category 3 Outcome Measure(s): West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems being selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This would equate to 34 persons indicating improved patient satisfaction due to the integrated service provision. Subsequently in DY 5 this expectation was increased to 40% or 55 persons indicating improved patient satisfaction due to the integration of services. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

Relationship to other Projects: West Texas Centers is also proposing Project Number 130725806.1.1 expansion of telemedicine services project and Project Number 130725806 expansion of WTC mobile crisis outreach staff.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects. The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders) in West Texas Center's Dawson County service area. The target population for this project will be persons experiencing a non urgent mental health event and meet the eligibility

requirements of the Department of State Health Services. Any person experiencing a behavioral health crisis event will be considered the target population for urgent/emergency treatment. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. With defined target populations, this project will promote the RHP goal of seeking to improve the health outcomes for targeted patients as well as the total population. It will compliment, but not duplicate other regional projects which may also be focused on expanding the access to specialty care and access to services. Regional projects by other behavioral health providers which are related include Helen Farabee Center' s project 133339505.1.1, Enhance behavioral health service availability and their project 127373205.1.1 , Expand Specialty Care Capacity. These projects cover different geographic areas within the RHP and concurrently support regional goals, but we do not believe this WTC project duplicates another provider's intervention for the same target population in the same geographic area.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	The project will provide onsite access to behavioral health care while facilitating more opportunities to address both the physical and mental needs of the consumer. Current integration with primary health care is limited to "crisis events" and limited coordination with PCP providers when patient needs overlap. Diversion from the emergency department and from potential incarceration/law enforcement involvement should occur more naturally and more effectively through the co-location arrangement. Through the integration of behavioral health and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Dawson County has limited public transportation. This project will enhance access to care as individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs.	**4**
Addresses Community Need(s)	The severe lack of mental health services, inability to get an appointment, lock of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP. This project will significantly meet this need. It will provide the first of its kind integration of behavioral health care and primary care in the rural counties we serve. This project brings to a very rural county a progressive, meaningful opportunity seldom available to rural counties such as Dawson.	**3**

Project Scope/Size	Currently West Texas Centers does not operate a co-located site with a primary care provider or a hospital. Preliminary discussions with community leaders in Dawson County have indicated there is a potential to lease space with a primary care provider. Extensive research has been done related to the patient experience, the cost effectiveness and the overall benefits to integration of behavioral and primary health care in America. Research indicates some of the benefits achieved through integrated service delivery include; improved recognition of mental health and physical health disorders, improved PCP and behavioral health provider's skills in medication prescription practices[1], increased PCP and behavioral health provider confidence in service delivery[2]. Co-location and service integration present increased opportunities for economies of scale in the delivery of patient services, to include collaboration of providers, more effective utilization of provider specialties, optimization of billing and reimbursement activities in addition to the more effective treatment of the patient as a whole.[3] This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives. This project will see a minimum of 110 individuals being served under the integrated care model receiving both primary and behavioral health care services at this site by DY 4. In DY 5 it is projected this number will increase to a 100% or approximately 138 patients receiving both primary and behavioral health care services. In addition in DY 4 a minimum of 20% or 27 of the 138 average number of WTC patients receiving services at the integrated location will have treatment plans developed and implemented with primary care and behavioral expertise indicated annually with that number increasing to 40% or 41 persons by DY 5. [1]Katon et.al. 1990 [2]Robinson et.al. 2009 [3]Mental Health America; Position Statement 13: Integration of Mental and General Health Care June 9, 2012	**5**
Project Investment	This project is West Texas Center's largest and most costly project among three of the four regional health service areas in which WTC serves counties.. This project will involve recruitment and training of an additional psychiatrist (.20 FTE), a .25 FTE registered nurse and at least 2 additional full time support staff. This project involves lease procurement and negotiations, legal consultation and potential renovation of the site. This project is the first of its' kind for the Center therefore elevated risk are expected. Implementation timeframes will be highly dependent upon facility readiness.	**5**

130725806.2.1	2.1	2.15.1 A-J	West Texas Centers Dawson County Behavioral and Primary Care Integration Project
West Texas Centers			130725806
130725806.3.2	OD-6	IT-6.1	Od-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores(standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-2(Cat 2, pg 320) Identify existing clinics or other community based settings where integration could be supported. Metric: P-2.1(Cat 2, pg 320): Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith based organizations and other community based helping organizations. Data Source: Information from persons interviewed Goal: to identify one location for integration Baseline: Currently there is no co-location arrangement between West Texas Centers and a primary care provider/facility therefore baseline for this milestone is N/A Milestone 1:Estimated Incentive Payment $200,657.00	Process Milestone 3 [P-X-1] (Cat 2 Pg 323): Complete lease arrangements for co-location/integration to include floor plan remodeling design and completion timeframes. Metric 1 [P-X.1]: Signed lease agreements and other related facility use agreements for integrated location. Data Source: Project data, lease documents, etc Baseline: Currently there is no co-location arrangement between West Texas Centers and a primary care provider/facility therefore baseline for this milestone is N/A Goal: To complete all necessary agreements at co-location/integration site to facilitate relocation of West Texas Centers Dawson County Mental Health Clinic to the new integrated location in DY 3.	Milestone 5: I-8 (Cat 2, pg 324) Integrated Services Metric: I-8.1 80% of individuals receiving both physical and behavioral health care at the established location. a. Numerator: Number of individuals receiving both physical health and behavioral health in the project sites. b. Denominator: Number of individuals receiving services in project sites. c. Data Source: Project data; claims and encounter data; medical records. Baseline: Dawson County WTC patient census DY 3. Goal: A minimum of 110 or 80% of the WTC annual patient population in Dawson County will be receiving both physical and behavioral health care at the established location Milestone 5 Estimated Incentive Payment: $225,148.50 Milestone 6:	Milestone 7: I-8(Cat 2, pg 324) Integrated Services Metric: I-8.1 100% of individuals receiving both physical and behavioral health care at the established location. a. Numerator: Number of individuals receiving both physical health and behavioral health in the project sites. b. Denominator: Number of individuals receiving services in project sites. c. Data Source: Project data; claims and encounter data; medical records. Baseline: Dawson County WTC patient census DY 3 Goal: A minimum of 138 or 100% of the WTC annual patient population in Dawson County will be receiving both physical and behavioral health care at the established location Milestone 7 Estimated Incentive Payment:

Milestone 2: P-4(Cat 2, pg 320) Assess ease of access to potential locations for project implementation. Metric 1: P-4.1(Cat 2, pg 321) Access to major highways, bus routes, or proximity to a large number of individual who may benefit from services. Baseline: City/Count Data, 2010 Census Data Source: a. City/County data, maps, demographic data relating to prevalence of health conditions. Goal: to determine best location for integration project related to patient access. Milestone 2: Estimated Incentive Payment: $200,657.00	Process Milestone 1 Estimated Incentive Payment: $210,474.50 Milestone 4: P-3(Cat 2, pg 320) Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. Metrics: P.3.1 Number and types of referrals that are made between providers at the location. Data Sources: Surveys of providers to determine the degree and quality of information sharing: Review of referral data and survey results P.3.2 Number of referrals that are made outside the location Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results. P.-3.3 Number of referrals which follow the established standards Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results. Baseline: No current baseline data available Goal: establish reliable data collection systems to determine baseline for identification of continuous improvement targets.	1-9 (Cat 2, pg 324) Coordination of Care Metric: I-9.1: 20% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. a. Numerator: Number of individuals with treatment plans developed and implemented with primary care and behavioral health expertise. b. Denominator: Number of individuals receiving services at project sites. Baseline: WTC Dawson County active caseload census and EHR patient records end of DY 3. Goal: A minimum of 20% or 27 of the 138 average number of WTC patients receiving services at the integrated location will have treatment plans developed and implemented with primary care and behavioral expertise indicated annually. Milestone 6 Estimated Incentive Payment: $225,148.50	$217,560.00 Milestone 8: 1-9 (Cat 2, pg 324) Coordination of Care Metric: I-9.1: 30% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. a. Numerator: Number of individuals with treatment plans developed and implemented with primary care and behavioral health expertise. b. Denominator: Number of individuals receiving services at project sites. c. Data Source: Project data; claims and encounter data; medical records Baseline: WTC Dawson County active caseload census and EHR patient records end of DY 3. Goal: A minimum of 30% or 41 of the 138 average number of WTC patients receiving services at the integrated location will have treatment plans developed and implemented with primary care and behavioral expertise indicated annually. Milestone 8 Estimated Incentive Payment: $217,560.00

	Milestone 4: Estimated Incentive Payment : $210,474.50		
Year 2 Estimated Milestone Bundle Amount: $401,314.00	Year 3 Estimated Milestone Bundle Amount: $420,949.00	Year 4 Estimated Milestone Bundle Amount: $450,297.00	Year 5 Estimated Milestone Bundle Amount: $435,120.00
Total Estimated Incentive Payments for 4-Year Period : $ 1,707,680.00			

Project Option: 2.6.2 Establish self-management programs and wellness using evidence-based designs
Performing Provider: Yoakum County Hospital - 137227806
Unique Identification Number: 137227806.2.1

Provider: Yoakum County Hospital (YCH) is a 24-bed Critical Access Hospital serving Denver City and Plains in Yoakum County (with approximately 8,000 residents in the county) and several surrounding communities (serving a draw area of over 25,000 from western Texas to the bordering areas of eastern New Mexico). Outpatient dialysis, home health, outpatient/inpatient hospital care, emergency/surgery services, and physician clinic services are offered in Denver City by the Yoakum County Hospital healthcare team.

Interventions: This project utilizes a new healthy lifestyle and wellness program via a "Preventive Medicine and Wellness Program "order sheet. Various coaching techniques for diabetic patients will provide a new process to follow up with diabetic patients on a routine basis, which will ultimately assist with self-management and reduce preventable readmissions for diabetics.

Need for the project: The disparity in admission rates was highest for diabetes without complications: patients from the poorest communities were hospitalized at a rate of 41.4 admissions per 100,000 populations—4.2 times higher than the admission rate for this condition in the wealthiest communities." http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp West Texas Medical Center (the Rural Health Clinic attached to YCH) is currently seeing diabetics less than two times per year on average instead of a consistent quarterly basis. This leads to less compliance with keeping hemoglobin A1c levels within control and more potentially preventable readmissions for diabetics.

Target population: The target population is any Medicaid and uninsured diabetic patient visits at West Texas Medical Center, the Plains Clinic, and Yoakum County Hospital. Between the Plains Clinic and West Texas Medical Center, 8,659 unique patients were seen. If 8.5% of diabetic patients are diagnosed in Yoakum County, then the total diagnosed diabetic population between the two Rural Health Clinics is 736 unique patients. 32% of patients are on Medicaid at West Texas Medical Center, 28% of patients are considered Medicaid from the Plains Clinic, and 15% of Yoakum County Hospital inpatient and outpatients are on Medicaid. 15% of Yoakum County Hospital patients are uninsured, 8% of West Texas Medical Center patients are uninsured, and 3% of the Plains Clinic patients are uninsured. 8.5% of Yoakum County is considered diabetic and 30% of Yoakum County is considered obese. The total estimated Medicaid and uninsured diabetic population between the two Rural Health Clinics should be equal to 300.

Category 2 expected patient benefits: This project will have the potential to see 500 patient visits each year with an emphasis of up to 250 Medicaid and uninsured diabetic patientvisits (100 unique patients) in DY5 to follow up with the Preventive Medicine and Wellness Program. We estimate 150 patient visits in DY4 (50 unique patients).

Category 3 outcomes: IT 3.3 – diabetes 30-day readmission rate. This project is brand new, so it is difficult to know what the real outcomes will be from YCH's efforts. Our estimate is that potentially preventable readmissions within 30 days for diabetes may be reduced by 3% from the efforts in DY2 – DY5.

Project Option: 2.6.2 Establish self-management programs and wellness using evidence-based designs
Performing Provider: Yoakum County Hospital - 137227806
Unique Identification Number: 137227806.2.1

- **Project Description – Project Option 2.6.2:** Much like a physician writing a referral to physical therapy, physicians will be provided with a mechanism to refer diabetic patients to a healthy lifestyle and wellness program via a "Preventive Medicine and Wellness Program "order sheet. This order sheet will list the patient's medical diagnosis as well as a listing of preventive medicine and wellness program offerings. The patient will take the order sheet to Yoakum County Hospital's wellness center(s) for program implementation and focus on self-management for diabetes. The major challenge with controlling diabetes is a lack of following through with self-management. This project will attempt to provide coaching techniques for diabetic patients and provide a process that will follow up with diabetic patients on a routine basis. The five-year goal is to educate 13.6% of all diabetic patients (100 unique patients who are on Medicaid or uninsured) who are seen at the Rural Health Clinics on self-management program offerings. This should lead to a five-year expected outcome of 3% less potentially preventable readmissions for diabetics who have their hemoglobin A1c levels out of control. This project is related to the regional goals by focusing on diabetes, which relates to obesity, heart disease, and many other chronic conditions that increase healthcare costs exponentially. This project meets community needs 5 on the RHP Region 12 Community Needs Assessment (CN.5 - Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, and chronic lung disease - BRFSS data source). There are three primary challenges involved with the referral of patients to the preventive medicine and wellness programs: 1) programs into which the patients will be referred need to be developed, 2) physician "buy in," and 3) patient adherence. The development of the preventive medicine and wellness programs will be done locally and will be based on current clinical evidence with special focus given to patient compliance. As the program offerings become more robust, increased physician referral is anticipated. This project will focus on all Medicaid and uninsured patients that have a visit (within the clinic software system EMD or the hospital electronic health record Paragon) in the Plains Clinic, West Texas Medical Center, or at Yoakum County Hospital.

  The healthcare team responsible for this project will be Mark Anna, FNP, Heather Milton - Administrative Assistant, Chris Ekrem - Chief Executive Officer, and TBD for YCH's Director of Nursing, and Jonna Marion, FNP. Mark Anna and Jonna Marion will be responsible for implementing the diabetic preventive medicine and wellness forms and evaluating each targeted diabetic with the form. Heather Milton will be responsible for setting up meetings with providers and the region to evaluate the success of the program. The Director of Nursing will find a diabetic educator for the hospital to enhance service offerings and Chris Ekrem will make sure that all barriers to success are eliminated where possible. The program will need to be developed with the overall

healthcare team. The proposed process will be the following: Step 1) Create a standardized preventive medicine and wellness form for diabetic patients (type 1 & type 2). Step 2) when a patient is diagnosed as having a need for diabetic education, the medical provider will order diabetic education with an order sheet. Step 4) the patient will be referred to a lifestyle center located in Plains or in Denver City (depending on patient preference). Step 5) the staff at the lifestyle center will fill the order and implement the program depending on the patients' needs. Step 6) After three months, the provider will follow up with the patient. Step 7) The provider will track improvements on a monthly basis and see the patient every three months. This project will affect the Plains Clinic, Yoakum County Hospital, and West Texas Medical Center (the Rural Health Clinic in Denver City).

- **Starting Point/Baseline:** This is a new project that has not been started; therefore, the baseline is zero. This plan will target our Medicaid and uninsured population. West Texas Medical Center (our Rural Health Clinic in Denver City) is approximately 32% Medicaid and the Plains Clinic (our Rural Health Clinic in Plains, Texas) is about 28% Medicaid. The uninsured population is 8% at West Texas Medical Center and the uninsured population is 3% at the Plains Clinic. The baseline begins at 0 in DY2.

- **Rationale:** By putting a tool into the hands of Yoakum County's medical providers to aid in the referral to wellness programs, the health of Yoakum County's citizens may be improved. The reasons for selecting the project option 2.6.2 are the following: 1) Yoakum County Hospital desires to innovate with new evidence-based programs, which promote integration with various chronic diseases. 2) This enhances service offerings to Yoakum County residents by delivering more choices to a variety of patients. 3) Reduce costs by providing more integrated diabetic education to our underserved patients in Yoakum County. 4) Experiment with innovative models to help keep diabetic patients accountable for their own health. The milestones selected are the following: P-3 - Implement, document and test an evidence-based innovative project for diabetic patients. P-3.1. Metric: Document implementation strategy and testing outcomes. a. Data Source: Yoakum County Hospital creation of workflow sheet for diabetic patients, documentation of workflow sheet usage, and document education given to diabetic patients. Implementation by March 1, 2012. b. Rationale/Evidence: Documentation of implementation strategy and testing outcomes to see if diabetic patients are really using recommended self-management techniques. The other milestone is P-6 - Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation should include: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. P-6.1. Metric: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. a. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. b.Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers to share best practices, learn how other providers have

overcome similar challenges, and rapidly disseminate successful improvement ideas from other providers. Mark Anna, FNP and Chris Ekrem, CEO at Yoakum County Hospital will coordinate with Heather Milton, Administrative Assistant to participate in webinars and conference calls with the regional hospitals. The target market will reside in zip codes 79323, 79355, and 79376 (all within Yoakum County). CQI is a required component and is performed inmilestone P-6Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation should include: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come.

This project meets community need 5 on the RHP Region 12 Community Needs Assessment (CN.5 - Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease - BRFSS data source). According to the 2012 County Health Rankings and Roadmaps, "30% of Yoakum County community members are obese (BMI greater than or equal to 30), 30% of the county is uninsured, 44% of restaurants are fast food, and 21% of children live in poverty. 8.5% of Yoakum County is diabetic and known for having challenges with medication compliance, eating healthy meals, and daily exercise." The RHP Region 12 Rural Community Needs Assessment described rural health challenges related to diabetes. "When asked about household members and physical activity in the previous 5 year period; 36% cited an overall lack of enough physical activity among household members. Twenty-two percent reported some physical limitation as preventing a household member from getting enough physical activity. Eighteen percent of respondents reported a lack of available time for physical activity. Sixteen percent lamented a lack of community recreation programs and facilities for adults and 8% reported a lack of accessible neighborhood playgrounds for children. Twelve percent of respondents reported a need for paved trails and sidewalks in their community and 9% commented on the general overall lack of parks and open public spaces. Thirty-two percent of respondents allowed that laziness might be a factor keeping their household member dormant. Thirty-one percent of respondents reported an obese household member, but only 5% reported a general lack of knowledge about nutrition. Thirteen percent of respondents stated they did not plan meals, and 8% blamed the cost of healthier nutrition habits. 33% of respondents reported unhealthy eating habits, and 8% were concerned about the availability of junk food and soda in the school."

I-8 Milestone: Increase access to health promotion programs and activities using innovative project option. I-8.1.
Metric: Increase percentage of target population reached. a. Numerator: Number of individuals of target population reached by the innovative project. b. Denominator: Number of individuals in the target population. c. Data Source: Documentation of target population reached, as designated in the project plan. d. Rationale/Evidence: This metric speaks to the efficacy of the innovative

project in reaching it targeted population. The idea is to reach as much of Yoakum County diabetics (8.5% throughout the county) with this evidence-based health promotion project to change behavior and keep hemoglobin A1c levels within control.

Diabetes is a major issue with regard to lower-income diabetic readmissions to Yoakum County Hospital. Disparities in "admission rates were evident for chronic conditions, where potentially preventable admission rates in the poorest communities were two to four times higher than those in the wealthiest communities. The disparity in admission rates was highest for diabetes without complications: patients from the poorest communities were hospitalized at a rate of 41.4 admissions per 100,000 populations—4.2 times higher than the admission rate for this condition in the wealthiest communities." http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp

"Similarly, patients from the poorest communities were hospitalized for diabetes with short-term complications at a rate of 91.6 admissions per 100,000 population, which was 2.7 times higher than the admission rate in wealthier communities. However, this variation was markedly lower for acute conditions, where admission rates in the poorest communities were 30 to 60 percent higher than those in the wealthiest communities." http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp

Data source: the estimates are based upon data from 2006 Nationwide Inpatient Sample (NIS). Population bases for rates were obtained from Claritas.

- **Related Category 3 Outcome Measure(s):**
  I chose diabetic PPR for category 3. Domain Number: OD-3 Diabetes PPR. Improvement Target: IT 3.3 Diabetes 30 day readmission rate. Potentially preventable readmissions within 30 days for diabetes is the outcome measure. The improvement target is IT 3.3 Diabetes 30 day readmission rate. Improvement targets will not be determined until there is more time to study appropriate outcome improvement targets in DY3. The main reason for selecting OD-3 Diabetes PPR is that diabetes has so many comorbidities associated with the chronic disease. Using potentially preventable readmissions will ensure that we are exploring the link between diabetic education, self-management techniques, and keeping hemoglobin A1c within control. It is also a measure of quality at a hospital. Improvement targets will not be determined until there is more time to study appropriate outcome improvement targets in DY3. The baseline will be determined in DY2 and DY3. The baseline is zero now.
  Diabetes is a major issue with regard to lower-income diabetic readmissions to Yoakum County Hospital. The disparity in admission rates was highest for diabetes without complications: patients from the poorest communities were hospitalized at a rate of 41.4 admissions per 100,000 populations—4.2 times higher than the admission rate for this condition in the wealthiest communities." http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp This project meets community need 5 on the RHP

Region 12 Community Needs Assessment (CN.5 - Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease - BRFSS data source). According to the 2012 County Health Rankings and Roadmaps, "30% of Yoakum County community members are obese (BMI greater than or equal to 30), 30% of the county is uninsured, 44% of restaurants are fast food, and 21% of children live in poverty. 8.5% of Yoakum County is diabetic and known for having challenges with medication compliance, eating healthy meals, and daily exercise." By keeping hemoglobin A1c levels within control, foot care on a consistent basis, and routine retinal screenings, Yoakum County hospital will attempt to reduce potentially preventable readmissions. The health of the community and financial stability of Yoakum County Hospital will be enhanced by treating diabetics consistently with better care coordination.

- **Relationship to other Projects:** This project relates to diabetic PPRs (category 3) for the same diabetic patients that will be given education on self management. Reduction in diabetic readmissions will lower costs to the hospital and the state of Texas while providing more optimal care to the Medicaid and uninsured population. This project is related to the category 3 unique project ID= 137227806.3.1.
- **Relationship to Other Performing Providers' Projects in the RHP:** N/A
- **Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to face-to-face meetings, we will have an open forum on our website that will foster communication amongst our partners with related projects.

- **Project Valuation:**

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project will reduce potentially preventable readmissions for diabetics, better serve the Medicaid and uninsured residents of Yoakum County by more optimal care coordination, reduce costs for Yoakum County Hospital and not be as much of a burden on local taxpayers. By reforming our current provider based model into a case-management model, our program "Wellness Team" will help coordinate program participants' care, working as an extension to our local medical providers. Our ultimate goal is to create a seamless network of care where patients suffering from these frustrating, expensive, and often difficult to manage chronic diseases and conditions will have a local advocate aiding in their daily care and adherence while assisting the medical providers with compliance to established best practice guidelines. This project has the 5 year potential to start making a difference in 100 Medicaid and uninsured diabetic patients and 250 patient visits per year in DY5.	**4**
Addresses Community Need(s)	This project meets community need 5 on the RHP Region 12 Community Needs Assessment (CN.5 - Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease - BRFSS data source). According to the 2012 County Health Rankings and Roadmaps, "30% of Yoakum County community members are obese (BMI greater than or equal to 30), 30% of the county is uninsured, 44% of restaurants are fast food, and 21% of children live in poverty. 8.5% of Yoakum County is diabetic and known for having challenges with medication compliance, eating healthy meals, and daily exercise." This project is related to several chronic conditions and addresses many other community needs by potentially reducing comorbidities associated with diabetes and possibly reversing type 2 diabetes in certain patients. The community need is considered urgent by the RHP Region 12 Community Needs Assessment.	**5**
Project Scope/Size	This project is large relative to other community education that Yoakum County Hospital is currently committed to. This will be a large project for mid-levels and physicians because of the new workflow, various forms, and system redesign. There should eventually be savings from this program related to decreased potentially preventable readmissions and admissions related to diabetes if hemoglobin A1c levels are within better control. In the spirit of "Program Innovation and Redesign," this project establishes a health promotion and disease prevention program which functions as an extension to the local medical providers and will be able to work daily with the patients, reporting to our local providers the patients' compliance to best practice guidelines for the numerous diseases and conditions we will address, essentially functioning as a local "case manager" to each participent.	**5**
Project Investment	The time to implement this program will be significant and will fall high on the priority list compared to many other organizational priorities (i.e. IT system additional purchases for the ER and physician documentation). In addition to a new wellness facility in the central Yoakum county area and revamping/redesigning the current wellness facility in Denver City, this program will require the recruitment	**3**

	and training of the health promotion and disease prevention program team (i.e. the Wellness Team). This team will have an innovative and unique skill set requiring "tech savvy," medically knowledgeable individuals with exemplary people skills including but not limited to a Wellness Program Director, Diabetic Educator, Mental Health Professional, and Wellness Assistants.		
137227806.2.1	**2.6.2**	**N/A**	**Establish self-management programs and wellness using evidence-based designs**
Yoakum County Hospital		**137227806**	
Related Category 3 Outcome Measure(s):	**137227806.3.1**	**IT-3.3**	**Diabetic 30 Day Readmission Rate**
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-3 Implement, document and test an evidence-based innovative project for diabetic Medicaid and uninsured patients **Metric: P-3.1** Document implementation strategy and testing outcomes. **Baseline/Goal:** Baseline is zero because it is a new project. Goal in DY2 is to get workflow sheet created and at least one mid-level using the workflow sheet for diabetic education. **Data Source:** Yoakum County Hospital creation of workflow sheet for diabetic patients, documentation of workflow sheet usage, and document education given to diabetic patients. Implementation by March 1, 2013. **Estimated Milestone 1 Incentive**	**Process Milestone 3:** : [RHP PP Milestone - P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric:** P-6.1 Metric: Number of monthly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: By DY3, one mid-level will be using the workflow sheet for diabetic education with the goal of one other mid-level and a physician using the workflow sheets by March 1, 2014 Numerator: Results of assessment **Data Source: Yoakum County Hospital creation of workflow sheet for diabetic patients, documentation of workflow sheet usage, and document education given to diabetic patients. Implementation**	**Milestone 6:** P-6 Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric P-6.1** Number of monthly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Two mid-levels and two physicians are using the workflow sheet for diabetic education by March 1, 2015 and we are now having monthly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Numerator: Number of patients	**Milestone 8: P-6** P-6 Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric:** P-6.1 Metric: Number of monthly meetings, conference calls, or webinars organized by the RHP that the provider participated in. **Baseline/Goal: Three mid-levels and two physicians are using the workflow sheet for diabetic education by March 1, 2016 and we are now having monthly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.** **Data Source: Documentation of monthly phone meetings,conference calls, or webinars including agendas**

Payment: $166,522.50 **Milestone 2**: [RHP PP Milestone - P-6]: Participate in at least monthly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric(s): [RHP PP Metric - P-6.1] Number of monthly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Baseline is zero because this is new. The goal is to participate in two meetings each month within the region. Data Source: Documentation of monthly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $166,522.50	**by March 1, 2014.** **Estimated Milestone 3 Incentive Payment:** **$128,680.66** **Milestone 4:** : [RHP PP Milestone - P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric(s): [RHP PP Metric - P-6.1] Number of monthly meetings, conference calls, or webinars organized by the RHP that the provider participated in. *Baseline/Goal:* *Baseline is now established with participating in two meetings each month within the region and sharing of best practices among the group.* Data Source: Documentation of monthly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $128,680.67 ***Milestone 5:*** I-8 increase access to health promotion programs and activities using innovative project option.Baseline/Goal: Baseline is zeroand the goal is to see 5% of	cared for by SNFist. Data Source: Documentation of monthly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. **Estimated Milestone 6 Incentive Payment: $195,016.00** **Milestone 7:** I-8 Increase access to health promotion programs and activities using innovative project option. Baseline/Goal: Baseline is 5% of the total Yoakum County Hospital Rural Clinics receiving self-management education for diabetes type 1 and 2 that are Medicaid/uninsured. The goal is to see 16.67% of Medicaid/uninsured diabetic patients, which is 50 unique Medicaid/uninsured diabetic patients Metric(s): I-8.1 - Increase percentage of target population reached. Numerator is number of individuals of target population reached by innovative project and the denominator is the number of individuals in the target population.	**for phone calls, slides from webinars, and/or meeting notes.** **Estimated Milestone 8 Incentive Payment: $167,085.00** **Milestone 9:** I-8 Increase access to health promotion programs and activities using innovative project option. Baseline/Goal: Baseline is 16.67% of the total Yoakum County Hospital Rural Clinics receiving self-management education for diabetes type 1 and 2 that are Medicaid/uninsured. The overall goal in DY5 is to see 100 unique (250 patient visits) Medicaid/uninsured patients (which is 33% of diabetic Medicaid/uninsured population). Metric(s): I-8.1 - Increase percentage of target population reached. Numerator is number of individuals of target population reached by innovative project and the denominator is the number of individuals in the target population. Data Source: Documentation of target population reached as designated in the project plan. We will use the Medicaid and uninsured patients who have type 1 and 2 diabetes. Milestone 9 Estimated Incentive Payment: $167,085.00

	Medicaid/uninsured diabetic patients, which is 15 unique Medicaid/uninsured diabetic patients (60 patient visits throughout DY3) of the total Yoakum County Hospital Rural Clinics receiving self-management education for diabetes type 1 and 2. Metric(s): I-8.1 - Increase percentage of target population reached. Numerator is number of individuals of target population reached by innovative project and the denominator is the number of individuals in the target population. Data Source: Documentation of target population reached as designated in the project plan. We will use the Medicaid and uninsured patients who have type 1 and 2 diabetes. Milestone 5 Estimated Incentive Payment: $128,680.67	Data Source: Documentation of target population reached as designated in the project plan. We will use the Medicaid and uninsured patients who have type 1 and 2 diabetes. Milestone 7 Estimated Incentive Payment: $195,016.00	
DY 2 Estimated Milestone Bundle Amount: $333,045	DY 3 Estimated Milestone Bundle Amount: $386,042	DY4 Estimated Milestone Bundle Amount: $390,032	*DY5 Estimated Milestone Bundle Amount: $334,170*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):$1,443,289			

Category 3: Quality Improvement

Outcome Measure Title: IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate

Performing Provider: Brownfield Regional Medical Center/130618504

Outcome Identification Number: 130618504.3.1

Outcome Domain: OD-2 Potentially Preventable Admissions

Outcome Measure Description: BRMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (IT-2.11) through a series of primary care expansion initiatives. We will develop and test data systems and collect baseline data in the first two years. The goal is to decrease the number of acute care hospitalizations of new BRMC clinic patients (as of DY3) for ambulatory care sensitive conditions under age 75 years by 4% in DY 4 and 8% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Expanding primary care clinic hours (130618504.1.1) will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting and expanding primary care hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions.

Rationale: The reason for selecting these process milestones and outcome improvement target achievement levels is because hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care; therefore, our improvement targets are to decrease the ACSC admission rate in DY 4-5. Since BRMC has not previously reported the ACSC admission rate, DY 2-3 will consist of developing data systems and measuring the baseline rate.

The Texas Department of State Health Services suggests that in Terry County alone there were approximately 874 potentially preventable hospitalizations from 2005-2010. These patients represented more than $16.5M in charges. A modest 6% reduction in potentially preventable hospitalizations over 5 years would result in $1M in savings.

While decreasing the ACSC admission rate alone can have a large cost savings, the chart below shows the estimated annual cost savings of expanding primary care access through extended clinic hours:

Estimated Annual Savings - Extended Clinic Hours	
Total New Clinic Patients	*1,725*
ED visits/year/person	*0.45*
Potential ED Visits	*778*
ED Visits Reduced @ 15%	*117*
Average ED Payment	*$ 425*
ED Savings	***$ 49,596***
IP Admissions/year/person	*0.11*
Potential IP Admissions	*197*
Admissions Reduced @ 18%	*35*
Average Total Medicare Costs/Discharge	*$ 12,354*
IP Admission Savings	***$437,141***
Total Estimated Savings	*$486,737*

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Extended hours and expanded primary care access will decrease acute care hospitalizations for ambulatory care sensitive conditions due to chronic disease management, preventive care, and follow-up care. Access to follow-up and preventive care through primary care will serve the Medicaid and uninsured residents of Terry County much more effectively and efficiently than the ED. This project primarily impacts Medicaid and/or uninsured residents since this population is most likely to receive primary care in the ED and be disconnected from a primary care provider. Decreasing the ACSC admission rate will move the dial considerably to decrease the cost of healthcare and improve health outcomes.	**5**
Addresses Community Need(s)	As sited in the community needs assessment (CN.1 and CN.4), there is a widespread critical shortage of primary care capacity and access to chronic disease management. More appointment availability through extended clinic hours will give patients better access to primary care and effectively decrease the ACSC admission rate. There is peer-review literature suggesting that extended hours will help to keep patients in a primary care clinic instead of the ED during nights and weekends. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."	**5**
Project Scope/Size	BRMC expects to see about 1,500 new patients. Considering the small population (~18,600) of Terry County, that is a considerable degree of primary care expansion. Decreasing the ACSC admission rate by 8% will be a considerable savings and health outcomes improvement.	**5**

Project Investment	Developing and testing the data systems to report acute care hospitalizations for ambulatory care sensitive conditions will require IT resources and administrative/clerical/nursing training to collect the necessary data. The extended hours will require additional physician, RN, and clerical staffing. It will also require additional IT and overhead expenses for reporting category 3 measures.	**5**

130618504.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
Brownfield Regional Medical Center			***130618504***
Related Category 1 or 2 Projects:	***130618504.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-3 Develop and test data systems **Metric:** Documentation of developed data system **Data Source**: EHR and claims **Process Milestone 1 Estimated Incentive Payment:** $ 51,106	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Numerator:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). **Denominator:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $ 59,239	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Numerator:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). **Denominator:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 4% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 95,058	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Numerator:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). **Denominator:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 8% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 227,312
Year 2 Estimated Outcome Amount: $51,106	Year 3 Estimated Outcome Amount: $59,239	Year 4 Estimated Outcome Amount: $95,058	Year 5 Estimated Outcome Amount: $227,312
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $432,715			

Outcome Measure Title: IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate

Performing Provider / TPI: Brownfield Regional Medical Center / 130618504

Outcome Identification Number: 130618504.3.3 – "PASS 3b"

Outcome Measure Description: BRMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation program (130618504.2.1). BRMC plans to develop and test data systems in DY 2. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions (ACSC) Admissions Rate. BRMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new BRMC primary care clinic patients as of DY 3—by 2% and 4% in demonstration years 4 and 5, respectively.

We propose to increase the overall quality of care and improve the health status of our target population—new BRMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease ACSC acute care hospitalizations due to expanded primary care access and improved preventive care.

Rationale: Hospitalization for an ambulatory care sensitive condition is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care; therefore, our milestones and improvement targets are to decrease the ACSC admission rate. The chart below shows the estimated annual cost savings of navigating non-urgent ED patients to the clinic.

Annual Savings from ED Visits Navigated to Clinic		
Total ED Visits (annual)		5,855
% Clinic Appropriate		15%
Clinic Appropriate Patients		878
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**373,256**
Clinic Payment @ 78% savings	$	82,116
Total Estimated Savings	**$**	**291,140**

The Texas Department of State Health Services suggests that in Terry County alone there were approximately 874 potentially preventable hospitalizations from 2005-2010. These patients represented more than $16.5M in charges.

Terry County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Terry County** received **$16,528,820** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Terry County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	20	65	56	16	11	11	179	$21,467	$3,842,595	$410
Dehydration	6	14	0	0	0	0	0	$0	$0	$0
Urinary Tract Infection	14	53	17	9	5	10	108	$13,057	$1,410,115	$150
Angina (without procedures)	0	6	0	0	0	0	0	$0	$0	$0
Congestive Heart Failure	42	87	72	23	25	28	277	$21,394	$5,926,267	$632
Hypertension (High Blood Pressure)	0	18	10	0	0	10	38	$13,165	$500,277	$53
Asthma	15	50	18	0	0	0	83	$10,071	$835,887	$89
Chronic Obstructive Pulmonary Disease	17	55	35	12	8	8	135	$13,950	$1,883,278	$201
Diabetes Short-term Complications	0	0	7	0	0	0	0	$0	$0	$0
Diabetes Long-term Complications	9	6	9	8	6	16	54	$39,452	$2,130,401	$227
TOTAL	**123**	**354**	**224**	**68**	**55**	**83**	**874**	**$18,912**	**$16,528,820**	**$1,764**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • Our ED navigation program will assure that patients receive high-quality and patient-centered care, in the most cost effective ways. Providing primary care in the clinic setting is certainly the most cost effective—much more efficient than the ED or inpatient hospitalization. Establishing ED navigators will create a patient-centered mindset and will decrease ACSC acute care hospitalizations due to expanded primary care access and improved preventive care. • Primary care will better serve the Medicaid and uninsured residents of the greater Brownfield community much more effectively than the ED—having access to follow-up and preventive care. • This project primarily impacts Medicaid and/or uninsured residents since this population is most likely to receive primary care in the ED and be disconnected from a primary care provider. • An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)." (Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)	**5**
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? • As sited in the community needs assessment (CN.1 and CN.4), there is a widespread critical need and shortage of primary care capacity and access and chronic disease management. ED navigators shifting patients to the clinic setting will expand access to primary and preventive care, improve access to chronic disease management, and decrease utilization of more costly care.	**5**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? • BRMC expects to navigate about 600 visits to the clinic setting. Considering the small population (~18,600) of Terry County, that is a considerable degree of primary care expansion and ED savings. • The March 2012 Executive Newsletter for HealthGrades reported that WellPoint, Inc. beneficiaries "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." The evidence of decreased admissions and ED visits revealed in these primary care based pilots shows that preventive care can lead to lower overall cost.	**5**
Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? • ED navigation and triage protocol will require additional staffing, IT hours, and overhead expenses for reporting category 3 measures.	**5**

130618504.3.3 – "PASS 3b"	*3.IT-2.11*	Ambulatory Care Sensitive Conditions Admissions Rate	
Brownfield Regional Medical Center			***130618504***
Related Category 1 or 2 Projects:	***130618504.2.2***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-3 Develop and test data systems **Metric:** Documentation of developed data system **Data Source**: EHR and claims **Process Milestone 1 Estimated Incentive Payment:** $ 26,417	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $ 29,313	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 2% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 44,762	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 4% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 102,912
Year 2 Estimated Total DSRIP Funding: $26,417	Year 3 Estimated Total DSRIP Funding: $29,313	Year 4 Estimated Total DSRIP Funding: $44,762	Year 5 Estimated Total DSRIP Funding: $102,912
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$203,405***			

Outcome Measure Title: TBD

Performing Provider: Central Plains Center/127374005

RHP Outcome Identification Number: 127374005.3.1

Outcome Measure Description: TBD
Outcome Improvement Targets for each year: TBD
Process Milestones:

- **DY3:**
  - **P-1: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implantation plans**
  - **P-2: Establish baseline rates (s)**
  - **P-3: Develop and test data systems**

Rationale:

- **DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans**
- **DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain**
- **DY3: P-3 – This step is necessary appropriateness and accuracy of the data**

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The impact of this project could be far-reaching, especially with further expansion in the coming years. This project will provide high-quality of services by combining two approaches for the purpose of treating people holistically. The project will draw upon two disciplines of treatment with improved outcomes for patients as mental and physical health are interwoven. Medical cost offset may occur when patients use less medical care because they are receiving mental health services. The reduced physical health care cost offsets the cost of the mental health care (Strosahl and Sobel 1996). This project will connect what have, historically, been two separate service systems serving the same patients. This will improve the healthcare infrastructure to better serve the Medicaid and uninsured as well as developing and maintaining a coordinated care delivery system.	**5**

Addresses Community Need(s)	This project meets several of the identified community needs as documented in the Community Needs Assessment Summary for RHP 12 including lack of mental health services; need to use ER for initial contact, poor insurance support or uninsured as well as addressing the issue of high incidences of obesity, diabetes mellitus and heart disease in our service areas. We anticipate that through this integration many patients being served in the physical care clinic who receive integrated treatment will experience improved health statuses. In the document "Evolving Models of Behavioral Health Integration in Primary Care" by Chris Collins, Denise Levis Hewson, Richard Mungar and Torlen Wade there is documentation that shows the far-reaching benefits of an integrated care model. It cites cost benefits, health outcome benefits as well as being beneficial and applicable to patients of all ages.	**5**
Project Scope/Size	In the article "Valuing the Integrated Primary and Mental Health Clinic Project Center for Health Care Services: Texas Healthcare Transformation and Quality Improvement" Prepared by H. Shelton Brown, A. Hasanat Alamgir, UT Houston School of Public Health, Thomas Bohman and the UT Austin Center for Social Work Research, they found "The benefits of the proposed co-location program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard." This research demonstrates the potential cost savings this project could render.	**5**
Project Investment	This project will require more health care provider's to be involved than the other project. The project is setup to hire and train individuals to support the integrated health project. Our overall focus will be on behavioral health staff and PCP working together as a team in treating patients. We think at this time very little will be needed in equipment or maintenance to support this project. Meeting the time line in implementing this project, should be relatively simple because of the organization, legal, professional and staff support that is available. During this time we will be evaluating the risk assessment over the years and make adjustment as identified.	**5**

127374005.3.1	**TBD**	**TBD**	
Central Plains Center		**127374005**	
Related Category 1 or 2 Projects:	**127374005.2.1**		
Starting Point/Baseline:	**Baseline info TBD**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
	Process Milestone 1: [P-1] Project planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source :**Data reports **Estimated Milestone 1 Incentive Payment:** $21,964 **Process Milestone 2: [P-2]** Establish baseline rates for Rate 1. **Data Source:** Data reports **Estimated Milestone 2 Incentive Payment:** $21,964 **Process Milestone 1: [P-3]** Develop and test data systems **Data Source :**Data reports, Business intelligence **Estimated Milestone 3 Incentive Payment:** $21,963	**Outcome Improvement Target 2: TBD** **Improvement Target:** TBD **Data Source:** TBD **Estimated Outcome Improvement Target 2 Incentive Payment:** $70,488	**Outcome Improvement Target 2: TBD** **Improvement Target:** TBD **Data Source:** TBD **Estimated Outcome Improvement Target 3 Incentive Payment:** $153,235
DY 2 Estimated Outcome Amount: $ 0	**DY 3 Estimated Outcome Amount:** $65,891	**DY 4 Estimated Outcome Amount:** $70,488	**DY 5 Estimated Outcome Amount:** $153,235
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: 289,614			

Outcome Measure Title: TBD

Performing Provider: Central Plains Center/127374005

RHP Outcome Identification Number: 127374005.3.2

Outcome Measure Description: TBD
Outcome Improvement Targets for each year: TBD
Process Milestones:

- **DY3:**
  - **P-1: Project Planning-engage stakeholders, identify current capacity and needed resources, determin timelines and document implantation plans**
  - **P-2: Establish baseline rates (s)**
  - **P-3: Develop and test data systems**

Rationale:

- **DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans**
- **DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain**
- **DY3: P-3 – This step is necessary appropriateness and accuracy of the data**

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project meets the triple aim of assuring patients receive high-quality and patient-centered care in the most cost effective way most significantly by addressing health risks of mental health consumers before their health risks are a more costly burden on the health care system. This peer project will enhance the health care infrastructure by identifying adults with co-morbid mental health and physical health risks. This has not occurred n our service area before and it is a missing link. The peer project further develop and maintain a coordinated care delivery system by being an integral cog in the wheel of linking individuals with health risks to the needed health care. By using a peer to connect with mental health consumers will ensure outcome improvement and keep cost down by preventing future health issues in a high risk population that has been underserved.	**4**
Addresses Community Need(s)	Our RHP's community needs summary identifies a lack of mental health services as well as the lack of primary care providers in our service area. This project seeks to get adults receiving mental health services in to needed medical treatment when there is a health risk present. The peers will be the tool used to make this connect and to provide encouragement and support.	**4**

Project Scope/Size	The target populations of this project are the adults receiving mental health services from Central Plains Center. The peers will be an integral part of our psychiatric clinic working closely with medical staff to identify consumers who would benefit from medical services to treat unidentified health risks. This project will affect individuals residing in our nine-county service area. In a given year, we serve over 1000 adults. This project will also work closely with our integration project in reaching out to the medical community to build relationships that will facilitate referrals and treatment for our consumers. We will provide interventions that will potentially prevent inpatient treatment episodes and emergency room usage.	**3**
Project Investment	This project will require more human resources than the other project because of the type of project. The project is setup to hire and train individuals to become Peer Specialist. Our overall focus will be on Peer to patient contact. We think at this time very little will be needed in equipment or maintenance to support this project. Meeting the time line in implementing this project should be relative simple because of the organization, legal, professional and staff support that is available. During this time we will be evaluating the risk assessment over the years and make adjustment as identified.	**3**

127374005.3.2	**TBD**	**TBD**	
Central Plains Center		**127374005**	
Related Category 1 or 2 Project(s):	**127374005.2.2**		
Starting Point/Baseline: TBD in DY3	**Baseline info TBD**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
	Process Milestone 1: [P-1] Project planning – engaged stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans **Data Source**: Data reports **Estimated Milestone 1 Incentive Payment**: $15,027 **Process Milestone 2: [P-2]** Establish baseline rates for Rate 1 **Data Source:** Data reports **Estimated Milestone 2 Incentive Payment:** $15,028 **Process Milestone 1: [P-3]** Develop and test data systems **Data Source:** Data reports, Business intelligence **Estimated Milestone 3 Incentive Payment:** $15,028	**Outcome Improvement Target 1:**TBD **Improvement Target:** TBD **Data Source:** TBD **Estimated Outcome Improvement Target 2 Incentive Payment:$**48,229	**Outcome Improvement Target 2:** TBD **Improvement Target:** TBD **Data Source:** TBD **Estimated Outcome Improvement Target 3 Incentive Payment:$**104,845
DY 2 Estimated Outcome Amount: $ 0	**DY 3 Estimated Outcome Amount:** $45,083	**DY 4 Estimated Outcome Amount:** $48,229	**DY 5 Estimated Outcome Amount:** $104,845
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $198,157			

Project Option: TBD

Performing Provider: Central Plains Center/127374005

RHP Outcome Identification Number: 127374005.3.3 – "PASS 2"

- Outcome Domain: Patient Satisfaction
- Domain Number: TBD
- Improvement Target: TBD

- Outcome Measure Description: TBD
- Outcome Improvement Targets for each year: TBD
- Process Milestones:
    - DY3:
        - P-1: Project Planning-engage stakeholders, identify current capacity and needed resources, determin timelines and document implantation plans
        - P-2: Establish baseline rates (s)
        - P-3: Develop and test data systems

- Rationale:
    - DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain
    - DY3: P-3 – This step is necessary appropriateness and accuracy of the data

- Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

  Achieves Waiver Goal: Score 3
  Addresses Community Needs: Score 3
  Project Scope/Size: Score 3
  Project Investment: Score 3

127374005.3.3 – "PASS 2"	**TBD**	**TBD**	
Central Plains Center			**127374005**
Related Category 1 or 2 Project(s): 127374005.1.1	**127374005.1.1**		
Starting Point/Baseline: TBD in DY3	**Baseline info TBD**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
	Process Milestone 1: [P-1} *Project planning – engaged stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans* *Data Source :Data reports* *Estimated Milestone 1 Incentive Payment:* *$5,418* *Process Milestone 2: [P-2}* *Establish baseline rates for Rate 1.* *Data Source :Data reports* *Estimated Milestone 2 Incentive Payment:* *$5,418* *Process Milestone 1: [P-3}* *Develop and test data systems*	*Outcome Improvement Target 1:* *Improvement Target:* *Data Source:TBD* *Estimated Outcome Improvement Target 2 Incentive Payment:$16,546*	*Outcome Improvement Target 2:* *Improvement Target:* *Data Source:TBD* *Estimated Outcome Improvement Target 3 Incentive Payment:$34,583*

	Data Source :Data reports, Business intelligence *Estimated Milestone 3 Incentive Payment:* *$5,418*		
DY 2 Estimated Outcome Amount: *0*	*DY 3 Estimated Outcome Amount:* *$16,253*	*DY 4 Estimated Outcome Amount:* *$16,546*	*DY 5 Estimated Outcome Amount:* *$34,583*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $67,383			

Outcome Measure: IT-3.2 Congestive Heart Failure 30 day Readmission Rate
Performing Provider: Childress Regional Medical Center/133250406
RHP Outcome Identification Number: 133250406.3.1

Outcome Domain: OD-3 Potentially Preventable Re-Admissions – 30 day readmission rates (PPR's)

Outcome Measure Description:

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. We believe there's more to the story than that…medication compliance, healthy habits, individual motivation, patient monitoring, etc…all play important roles.

We are confident that we can drive down readmission rates specific to CHF patients through a comprehensive approach. We will complete project planning in DY2, then develop and test our systems in DY3. By DY4, we will target and reach out to CHF patients with home visits, teaching and support. We believe this approach has the potential to drive down CHF 30 day readmission rates by 10% or more over the life of the project.

This outcome project is directly related to our category 1 project (1.6 – Enhance Urgent Medical Advice). When patients can get their health related questions answered by a professional in a timely manner, their anxiety is reduced. When we educate ER patients being treated for CHF to utilize the urgent advice line as they have symptoms, they will access care more appropriately. And when we assign a team to proactively address medication compliance, vital sign monitoring, and other readmission triggers, their health will improve and costs will decrease.

Rationale:

We are starting to gather readmission data specific to diagnosis, and see an opportunity for improvement through focused effort. We selected the planning in systems testing process milestones in early years because we feel it's important to be deliberate to achieve sustained success. Although we don't yet have baseline data, outcome improvement targets will be determined in DY2 for implementation in the following years.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Readmissions are at the heart of problems with American healthcare delivery. Systems are fractured and patients fall through the cracks. Readmissions signal a failure. By designing care systems from a patient point of view, we better serve them. And by proactively seeking to care for CHF patients in their home environment, readmission rates (and healthcare costs) will drop. Preliminary evidence of a program in Camden, NJ show that a technique called "hotspotting" has resulted in visit and cost reductions of 40 – 50% among that city's sickest patients.	**5**
Addresses Community Need(s)	This project certainly addresses a pressing community need – CN.2 in our regional needs assessment identifies non-urgent ED utilization as a critical need. Readmissions affect CHF patients with multiple hospital stays, but it also has a global effect on facility staffing and global healthcare cost. The Affordable Care Act (federal) and Medicaid (state) are for the first time assessing reimbursement penalties to hospitals who have high readmission rates.	**5**
Project Scope/Size	The size of this project presents a challenge. Achievement will take a concerted effort from multiple hospital departments, and require our staff to change historical norms. We've got to take care to our CHF patients, which we have never done.	**5**
Project Investment	We are only proposing one other Category III project due to the limited nature of our allocation. But CHF readmission reduction is a significant initiative. It has the potential to save significant dollars associated with non-urgent ED utilization and hospital readmissions.	**4**

133250406.3.1	3.IT-3.2	Congestive Heart Failure 30 day readmission rate	
Childress Regional Medical Center			133250406
Related Category 1 or 2 Projects:	133250406.1.1		
Starting Point/Baseline:	Unknown/TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Hospital Documentation **Process Milestone 1 Estimated Incentive Payment:** $12,144 **Process Milestone 2 [P-2]:** Establish baseline rates **Numerator:** CHF readmissions Denominator: Total hospital admissions **Data Source:** Hospital Documentation **Process Milestone 2 Estimated Incentive Payment:** $12,144	**Process Milestone 3 [P-2]:** Develop and test data systems **Data Source:** Hospital Documentation **Process Milestone 3 Estimated Incentive Payment:** $28,153	**Outcome Improvement Target 1: [IT-3.2]:** Congestive Heart Failure 30 day readmission rate Improvement Target: Reduce targeted CHF readmission rate by 5% **Data Source:** Hospital reports **Outcome Improvement Target 1 Estimated Incentive Payment:** $45,176	**Outcome Improvement Target 2: [IT-3.2]:** Congestive Heart Failure 30 day readmission rate **Improvement Target:** Reduce targeted CHF readmission rate by 10% **Data Source:** Hospital reports **Outcome Improvement Target 2 Estimated Incentive Payment:** $108,030
Year 2 Estimated Outcome Amount: $24,288	**Year 3 Estimated Outcome Amount:** $28,153	**Year 4 Estimated Outcome Amount:** $45,176	**Year 5 Estimated Outcome Amount:** $108,030
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $205,647			

Outcome Measure Title: IT-6.1 Percent Improvement over baseline of patient satisfaction scores
Performing Provider: Childress Regional Medical Center/133250406
RHP Outcome Identification Number: 133250406.3.2

Domain Number: OD-6 – Patient Satisfaction

Outcome Measure Description:

Rural hospitals perform relatively well when it comes to patient satisfaction scores because we have a familiarity with our patients but patient access issues can lead to frustration and lack of capital can keep rural hospitals from acting on new service offerings.

We are committed to initiating a patient centered medical home program and we believe effective deployment of that system will help us achieve outstanding patient satisfaction scores. We will plan project details in DY2 and gather baseline data in DY3. By DY4, we hope to see improvement in patient satisfaction scores aimed at patient's involvement in shared decision making. We believe this approach has the potential to improve our patient satisfaction scores by 5 - 10% over the life of the project. This outcome project is directly tied to our category 2 project (2.1 – Enhance/Expand Medical Home in HPSA) and our target population for this project will be low-level (1, 2, & 3) encounters to our ER.

There is a direct tie between Medical Home adoption and patient satisfaction. When patients access care in the appropriate setting, and get a dedicated team of health professionals dealing with their chronic conditions in a primary care setting, their satisfaction with the process will improve, while the system saves cost.

Rationale:

We have participated in HCAHPs surveying and trended scoring for several years, and we recognize an opportunity for improvement through focused effort.

In DY2 and DY3, we will engage in project planning because we feel it's important to be methodical to achieve sustained success. We will establish baseline rates because we don't yet have data specific to the targeted question – patient involvement in shared decision making.

Outcome improvement targets will be determined for implementation in following years.

In DY4 and DY5, we plan to demonstrate success with satisfaction scores related to shared decision making that show improvement of 5 – 10%.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Patients get frustrated by a lack of access or communication in American healthcare delivery. Systems are fractured and patients fall through the cracks. Declining patient satisfaction scores signal a problem with both the quality and cost of care. By designing care systems from a patient point of view, we better serve them. And by proactively seeking to meet patient needs, our hospital's satisfaction scores should improve.	**5**
Addresses Community Need(s)	Patient satisfaction scores are an indicator of how well a hospital is meeting overall community need. Even when there is slight variance among survey questions, an overall rating gives insight into community perception of its local hospital.	**5**
Project Scope/Size	The scope of this project is significant. Achievement of improvement targets will take more than just a telephone triage system and a desire to improve. Every hospital employee will have to understand their role and be diligent to provide outstanding service under challenging circumstances. We will have to be prepared to meet the needs of every patient that walks through our doors, and be willing to involve them in care decisions.	**5**
Project Investment	We are only proposing one other Category III project due to the limited nature of our allocation. But patient satisfaction score improvement is a significant initiative. The investment will be primarily in labor costs and staff training.	**4**

133250406.3.2	**3.IT-6.1**	Percent Improvement over baseline of patient satisfaction scores	
Childress Regional Medical Center		**133250406**	
Related Category 1 or 2 Project(s):	**133250406.2.1**		
Starting Point/Baseline:	**We don't yet have scoring specific to patient's involvement in shared decision making**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Project Planning **Data Source:** Hospital Documentation **Process Milestone 1 Estimated Incentive Payment:** $24,288	**Process Milestone 2: P-3** Establish Baseline Rates **Data Source:** Hospital Documentation **Process Milestone 2 Estimated Incentive Payment:** $28,153	**Outcome Improvement Target 1: IT-6.1** **Improvement Target:** Improve Satisfaction Score by 5% above baseline **Data Source:** Hospital Reports **Estimated Outcome Improvement Target 1 Incentive Payment:$**45,176	**Outcome Improvement Target 2: [IT-1.1]** **Improvement Target:** Improve Satisfaction Score by 7.5% above baseline **Data Source:** Hospital Reports **Estimated Outcome Improvement Target 2 Incentive Payment:$**108,030
DY 2 Estimated Outcome Amount: $24,288	**DY 3 Estimated Outcome Amount:** $28,153	**DY 4 Estimated Outcome Amount:** $45,176	**DY 5 Estimated Outcome Amount:** $108,030
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $205,647			

Outcome Measure Title: IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)
Performing Provider: Childress Regional Medical Center/133250406
RHP Outcome Identification Number: 133250406.3.4 -**"PASS 3b"**

Domain Number: OD-13 Palliative Care

Outcome Measure Description:

We aim to initiate a palliative care program, which to date has been an unmet patient need, in Childress County. We will establish an interdisciplinary care team that will provide medical care as well as advanced symptom management services. As outcome goals shift from cure at any cost to relief and prevention of suffering, palliative care services provide real value to patients and the healthcare system.

Palliative care has been shown to be cost efficient and result in high patient and family satisfaction. The needs of these patients are often very complex and a team of professionals, each expert in their own area is key to successful interventions. We aim to initiate palliative care services that improve patient outcomes and quality of life.

This outcome measure will test the success of our palliative care initiative's effectiveness. If we are doing our job, patients will avoid ER visits and over-treatment in the final days of life. This outcome project is directly tied to our category 2 project (2.2 – Palliative Care) and our target population for this project will be those patients who don't meet home health or hospice criteria. We expect that population to be 20 – 30 patients (and up to 1,000 annual visits) in DY3 – DY5. Since palliative care services aren't currently covered by Medicare or Medicaid, we expect our unfunded patient percentage to exceed 80%.

Rationale:

Most adults prefer to be cared for at home if terminally ill and the majority would be interested in a comprehensive program of end of life care, such as hospice. Although most Americans would prefer to die in their home, most die in institutions. Approximately 50% of DNR's are written within two days of death. Often, a patient's preference to forego resuscitation is unknown or disregarded (Middlewood et al., 2001). The Journal of the American Medical Association (19:281(2);163-168) identified patients in palliative care programs need the following: pain and symptom control, no inappropriate prolongation of the dying process, a sense of control, less burdens for the family, and a strong relationship with family. A CRMC palliative care program can support the complex needs of the patient and their caregivers in a clinical setting.

It has been demonstrated that palliative care teams in hospitals improve multiple outcomes including both clinical and financial. Patient illness/dying trajectories often result in slow decline, periodic crises, and death (e.g. congestive heart failure). These are the most frequently readmitted patients who represent significant savings potential if our systems of care can be transformed.

There is emerging literature that shows palliative care teams improve patient and family satisfaction with care at the end of life. Specifically, palliative care teams can assist with pain and symptom management, recognition of the patient as a whole person, clear medical decision-making, life completion and preparation for death. Palliative care consultations have been clearly associated with decreased costs of care at the end of life and higher quality of life in the week before death.

The primary goal of this project is to enhance end of life care for Childress patients to better accommodate the needs of the patient population, families, and community. Patients should receive dignified and culturally appropriate care to relieve suffering in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences. CRMC sees a disproportionately large number of patients who are under- or uninsured, non-English speaking, or of lower socioeconomic status, who often presents with more advanced illness and have fewer treatment options. For these reasons, we see a large number of patients with a high symptom burden and poor prognosis.

As we measure end of life ER visits among our palliative care participants, we will know if the work we do is effective. Palliative care teams are instrumental in assisting with transitions in care such as moving from cancer treatment to comfort care. Conversations about preferences for end-of-life care have been shown to improve quality of life for patients and caregiver bereavement. Additionally, palliative care can and should be provided to any patient with suffering, regardless of their prognosis or options for life-prolonging treatments.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	A waiver goal is to reduce non-emergent ED visits, and lack of a local palliative care program drives poor utilization of services. A successfully implemented palliative care program will improve utilization at the end of life and achieve waiver goals. This palliative care intervention greatly helps to further the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. Most patients prefer to die at home however most patients die in the hospital because they did not have access to high quality palliative care programs. This project will serve the Medicaid and uninsured residents of our county. Numerous studies have shown that Palliative care will Improve outcomes while containing cost growth by reducing unnecessary admissions and readmissions.	**4**
Addresses Community Need(s)	Palliative care is an unmet community need. Currently there is no local access to high quality palliative care. Within our county, hospital patients who have Medicaid or are underinsured are frequently faced with critical illness or end of life issues. As this facility serves as the safety net hospital for the area it is critical that high quality palliative care programs exist to meet this need.	**4**

Project Scope/Size	The scope of our palliative care program will be moderate. We're a small community, but we know there are patients who fall through the cracks of coordinated care programs. In the end, everyone faces death and it is critical that patients receive high quality end of life care. This is true regardless of the economic class or ethnic background. While death is ubiquitous each person is unique. It is critical that each person's end of life care is centered on their unique needs. In this way the various cultures and ethnic groups can receive culturally appropriate care at such an important time as critical illness and end of life.	**3**
Project Investment	The major capital needed to deliver high quality care is the time of the professionals who will be working with the patients and their families to deliver this care. As might be expected this can be considerable as families grapple with the very difficult decisions regarding their loved ones. Palliative medicine is a multi-disciplinary field and practitioners from across medicine will have to be engaged. From social workers to chaplains to nurse managers to physicians - all are integral to an effective team	**3**

133250406.3.4 – "PASS 3b"	IT-13.3	Proportion with more than one emergency room visit in the last days of life (NQF0211)	
Childress Regional Medical Center		**133250406**	
Related Category 1 or 2 Project(s):	**133250406.2.3**		
Starting Point/Baseline:	***There is currently no palliative care program in Childress, and no data regarding ER visits in the last days of life***		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Project Planning **Data Source:** Hospital Documentation **Process Milestone 1 Estimated Incentive Payment:** $52,683	**Process Milestone 2: P-2** Establish Baseline Rates **Data Source:** Hospital Documentation **Process Milestone 2 Estimated Incentive Payment:** $58,459	**Outcome Improvement Target IT-13.3:** Proportion with more than one emergency room visit in the last days of life (NQF0211) **Improvement Target:** Baseline: unknown Goal: 15% improvement **Data Source:** E H R, claims **Estimated Outcome Improvement Target 1 Incentive Payment:$**89,269	**Outcome Improvement Target 2: [IT-13.3]** Proportion with more than one emergency room visit in the last days of life (NQF0211) **Improvement Target:** Baseline: unknown Goal: 25% improvement **Data Source:** E H R, claims **Estimated Outcome Improvement Target 2 Incentive Payment:$**205,235
DY 2 Estimated Outcome Amount: $52,683	**DY 3 Estimated Outcome Amount:** $58,459	**DY 4 Estimated Outcome Amount:** $89,269	**DY 5 Estimated Outcome Amount:** $205,235
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $405,646			

Outcome Measure Title: IT-2.10 Improvement in Flu and Pneumonia Admission Rate
Performing Provider: City of Amarillo/Pending
Unique RPH outcome identification numbers: Pending.3.1

Outcome Measure Description:
IT-2.10 Improvement in Flu and Pneumonia Admission Rate

a) Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
b) Denominator: Population in Metro Area or county, age 18 years and older.
c) Data Source: EHR, Claims

Process Milestones:

DY3: Milestone 2:

P-2: Establish baseline rates

Outcome Measure Improvement Targets

DY4: Outcome Improvement Target 1: IT 2.10: Reduce admission rate over baseline among low income adult clinic clients for vaccine preventable diseases such as bacterial pneumonia and influenza over time.

DY5: Outcome Improvement Target 2: **IT 2.10** Reduce admission rate by TBD% among low income adult clinic clients for vaccine preventable diseases such as bacterial pneumonia and influenza over DY4.

Rationale

This outcome measure is the most logical way to estimate the improvements, attributable to this particular public health intervention, over time. This is a standalone measure designed to track the outcome targets of this project and is unique to immunization programs. The actual percentages of improvement in this target measure will be adjusted after the program begins to allow flexibility to adjust or modify the program components to allow for the most improvement possible based on the data gathered at the inception of the project.

Outcome Measure Valuation:

This project is valued to implement cost-savings interventions of immunizations to address the $98 million dollars spent over a 5 year period in bacterial pneumonia infections in Potter and Randall Counties. The average cost of these hospitalizations is $28,110 per admission on average. Subsequent to this analysis, the cost of routine vaccination for these conditions seems to be an obvious intervention with the potential for staggering cost savings over time. While the budget includes vaccine, staffing, medical supplies and a mobile clinic vehicle, it should be a cost-effective program overall. In fact, of the $9.8 million dollar investment, it will only require the prevention of 349 cases of bacterial pneumonia and influenza to become budget neutral over 5 years. This program anticipates providing over 15,000 immunizations.

Pending.3.1	3.IT-2.10	Improvement in Flu and Pneumonia Admission Rate	
City of Amarillo Department of Public Health			**Pending**
Related Category 1 or 2 Project	Pending.2.1		
Starting Point/Baseline:	To be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 2: **P-2**: Establish baseline rates **Data Source:** Program documentation, EMR **Milestone 2 Estimated Incentive Payment: $236,976**	**Outcome Improvement Target 1:** **IT 2.10**: Flu and pneumonia Admission Rate **Goal:** Demonstrate TBD% reduction in admission rate for vaccine preventable diseases among low income adult clinic clients from baseline. **Data Source:** Hospital discharge data, Amarillo Department of Public Health **Outcome Estimated Incentive Payment: $253,510**	**Outcome Improvement Target:** **IT 2.10**: **Flu and pneumonia Admission Rate** **Goal:** Demonstrate TBD% reduction in admission rate for vaccine preventable diseases among low income adult clinic clients from DY4. **Data Source**: Hospital discharge data, health records, internal data systems **Outcome Estimated Incentive Payment: $551,108**
Year 2 Estimated Milestone Bundle Amount $0	**Year 3 Estimated Outcome Amount:** $236,976	**Year 4 Estimated Outcome Amount:** $253,510	**Year 5 Estimated Outcome Amount:** $551,108
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$1,041,594**

Outcome Measure Title: IT 9.1 Decrease Substance Abuse Admissions/Readmissions to the Criminal Justice System
Performing Provider: City of Amarillo/Pending
Unique RPH outcome identification numbers: Pending.3.2 – "PASS 2"

Outcome Measure Description:

Outcome Measure for IT 9.1: Decrease admissions/readmissions to the criminal justice system.

- The ARAD project is specifically designed to facilitate the 30-day treatment and counseling program to reduce arrests due to substance abuse issues for homeless/underserved indigent people living in Amarillo. This program includes partnerships for transportation and community shelters to maximize compliance with the target population. These components are typical weaknesses in other similar project but the ARAD elements should maximize the intended reductions in arrests.

Process Milestones:

- DY2: P-1: Project planning for ARAD program intervention
- DY3: P-2: Determine baseline rates for criminal justice admissions/readmissions

Outcome Improvement Targets for each year:

- DY4: IT 9.1: Decrease in mental health admissions and readmissions to criminal justice settings by 5%
- DY5: IT 9.1: Decrease in mental health admissions and readmissions to criminal justice settings by 10% over baseline

Rationale: Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. The process milestones reflect the program design and implementation. The improvement targets were chosen as indicators of success while establishing a realistic attainment goal.

Outcome Measure Valuation: The ARAD program will target indigent populations that traditionally rely on third-party payers like Medicaid to pay for ancillary services related to substance abuse. These populations are known to seek medical treatment in inefficient areas such as Emergency Departments, Medicaid primary care providers and urgent care centers. Substance abuse diagnoses count for millions of dollars over the 5-year DSRIP cycle. Because of these high cost drivers of substance abuse referrals from criminal justice settings to hospitals in emergencies, the 1115 Waiver goals of reducing costs, increasing regional partnerships leveraging services and addressing community needs are all met in this project.

Pendin.3.2 – "PASS 2"	3.IT-9.1	Criminal Justice Admission/Readmission Rate	
City of Amarillo Department of Public Health ARAD Project			Pending TPI
Related Category 1 or 2 Projects:	Pending.2.2		
Starting Point/Baseline:	No program currently exist for indigent target population		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: Project planning for ARAD program intervention Metric 1: Develop operational plan for ARAD intervention **Baseline**: no program exists **Data Source**: Program documentation.	**Milestone 2: Determine baseline rates for criminal justice admissions/readmissions** Metric 1: Rate of criminal justice admission/readmission of the target population of indigent patients **Baseline**/Goal: Baseline is 0. **Data Source**: Program documentation	**IT: 9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons *(Standalone measure)*** **Numerator:** The number of individuals receiving project intervention(s) that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period. **Denominator:** The number of individuals receiving project intervention(s) **Goal:** Demonstrate 5% reduction in admission/readmission rate for target population to the criminal justice system due to substance abuse issues **Data Sources**: Criminal justice system records, local MH authority and state MH data system records	**IT: 9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons *(Standalone measure)*** **Numerator:** The number of individuals receiving project intervention(s) that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period. **Denominator:** The number of individuals receiving project intervention(s) **Goal:** Demonstrate 10% reduction over baseline in admission/readmission rate for target population to the criminal justice system due to substance abuse issues **Data Sources**: Claims/ encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records
Year 2 Estimated Outcome Amount: **$0**	Year 3 Estimated Outcome Amount: **$34,708**	Year 4 Estimated Outcome Amount: **$35,333**	Year 5 Estimated Outcome Amount: **$73,849**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$143,890**			

Outcome Measure Title: IT-7.7 Urgent Dental Care Needs in Older Adults
Performing Provider: City of Lubbock Health Department/135103304
Unique RHP Outcome ID: 135103304.3.1
Outcome Domain: OD-7 Oral Health

Outcome Measure Description:

IT-7.7 - Urgent Dental Care Needs in Older Adults

In order to achieve the goals and desired outcomes of this project, the following Process Milestones and Outcome Improvement Targets were selected:

Process Milestones:

Year DY2:

Category 3 – P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness, and document implementation plans.
Data Source: Implementation plan

Year DY3:

Category 3 – P-2: Establish baseline rates
Data Source: Performing Provider Utilization Data, Emergency Department Data

Outcome Improvement Targets:

Year DY4:

IT – 7.7: Urgent dental care needs in older adults
Improvement Target: Decrease the number of older adults 65 years or older with urgent dental care needs by 10% from baseline
Data Source: EHR, claims

Year DY5:

IT – 7.7: Urgent dental care needs in older adults
Improvement Target: Decrease the number of older adults 65 years or older with urgent dental care needs by 15% from baseline
Data Source: EHR, claims

Rationale:

The above outcome measure, process milestones and outcome improvement targets were selected because they directly address Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* Establishment of a new dental clinic will allow people access to specialized interventions, in order to avoid exacerbation of health problems.

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure patients receive coordinated, timely and site-appropriate healthcare services. The City of Lubbock hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	**5**
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. The City of Lubbock's new dental clinic directly relates to the Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* Establishment of a new dental clinic will allow people access to specialized interventions, in order to avoid exacerbation of health problems.	**5**
Project Scope/Size Scale: 1 to 5	During DY3 the City of Lubbock will hire and train staff, develop all operational protocols and clinical guidelines and develop a baseline from which to calculate system improvements. The City of Lubbock hopes to provide at least 600 office visits during DY4 and to provide at least 750 office visits in DY5. Conceivably, over 350 people per year could be impacted by this project. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4	**4**

5 Greatest	and 15% over baseline in DY5. In DY4, the City of Lubbock hopes to decrease the number of elderly adults with urgent care needs by 10% under baseline and to decrease 15% under baseline in DY5.When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	
Project Investment Scale: 1 to 5 5 Greatest	The City of Lubbock's investment in this project will be fairly significant. Staffing will include a Program Director, Dentist(s), Licensed Hygienists, Dentals Technicians, office personnel, etc. (Some administrative staff will be shared with StarCare and Combest in order to obtain economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc. As one might imagine, dental equipment can be very expensive.	**4**

135103304.3.1	**3.IT-7.7**	**Urgent dental care needs in older adults**	
City of Lubbock, Health Department		**135103304**	
Related Category Project:	**135103304.1.1**		
Starting Point/Baseline:	**To be determined in DY3**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans. **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $102,222	**Process Milestone 2: P-2** Establish baseline rates **Data Source:** PP Utilization Data, Clinic Utilization Data **Process Milestone 2 Estimated Incentive Payment:** $236,977	**Outcome Improvement Target 1: IT7.7:** Urgent dental care needs in older adults **Improvement Target:** Decrease the number of older adults 65 years or older with urgent dental care needs by 10% from baseline **Data Source:** PP Utilization Data, Clinic Utilization Data **Estimated Outcome Improvement Target 1 Incentive Payment:** $253,510	**Outcome Improvement Target 2: IT7.7:** Urgent dental care needs in older adults **Improvement Target:** Decrease the number of older adults 65 years or older with urgent dental care needs by 15% from baseline **Data Source:** PP Utilization Data, Clinic Utilization Data **Estimated Outcome Improvement Target 2 Incentive Payment:** $551,109
DY 2 Estimated Outcome Amount: $102,222	***DY 3 Estimated Outcome Amount:*** $236,977	***DY 4 Estimated Outcome Amount:*** $253,510	***DY 5 Estimated Outcome Amount:*** $551,109
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,143,817			

Outcome Measure Title: IT-7.7 Urgent Dental Care Needs in Older Adults
Performing Provider: City of Lubbock Health Department/135103304
Unique RHP Outcome ID: 135103304.3.2 **"PASS 2"**
Outcome Domain: OD-7 Oral Health

Outcome Measure Description:

IT-7.7 - Urgent Dental Care Needs in Older Adults

In order to achieve the goals and desired outcomes of this project, the following Process Milestones and Outcome Improvement Targets were selected:

Process Milestones:

Year DY2:

Category 3 – P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness, and document implementation plans.
Data Source: Implementation plan

Year DY3:

Category 3 – P-2: Establish baseline rates
Data Source: Performing Provider Utilization Data, Emergency Department Data

Outcome Improvement Targets:

Year DY4:

IT – 7.7: Urgent dental care needs in older adults
Improvement Target: Decrease the number of older adults 65 years or older with urgent dental care needs by 10% from baseline
Data Source: EHR, claims

Year DY5:

IT – 7.7: Urgent dental care needs in older adults
Improvement Target: Decrease the number of older adults 65 years or older with urgent dental care needs by 15% from baseline
Data Source: EHR, claims

Rationale:
The above outcome measure, process milestones and outcome improvement targets were selected because they directly address Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* Establishment of a new dental clinic will allow people access to specialized interventions, in order to avoid exacerbation of health problems.

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure patients receive coordinated, timely and site-appropriate healthcare services. The City of Lubbock hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	**5**
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. The City of Lubbock's new dental clinic directly relates to the Region 12 Community Needs Assessment ID# CN13 (Important Need): *There is a shortage of dental care;* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* Establishment of a new dental clinic will allow people access to specialized interventions, in order to avoid exacerbation of health problems.	**5**
Project Scope/Size Scale: 1 to 5 5 Greatest	During DY3 the City of Lubbock will hire and train staff, develop all operational protocols and clinical guidelines and develop a baseline from which to calculate system improvements. With Pass 1 funding, the City of Lubbock plans to provide at least 600 office visits in DY4 and to provide at least 750 office visits in DY5, serving 350 people per year. Pass 2 funding will allow the City of Lubbock to provide an additional 250 office visits each year in DY4 and DY5, with capacity to serve 147 more people each year. The City of Lubbock will focus upon special needs patients, pregnant women and/or the elderly hoping for a 10% increase over baseline in DY4 and 15% over baseline in DY5. 10% increase over baseline in DY4 and 15% over baseline in DY5. In DY4, the City of Lubbock hopes to decrease the number of elderly adults with urgent care needs by 10% under baseline and to decrease 15% under baseline in DY5.When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	**4**
Project Investment Scale: 1 to 5 5 Greatest	The City of Lubbock's investment in this project will be fairly significant. Staffing will include a Program Director, Dentist(s), Licensed Hygienists, Dentals Technicians, office personnel, etc. (Some administrative staff will be shared with StarCare and Combest in order to obtain economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc. As one might imagine, dental equipment can be very expensive.	**4**

135103304.3.2	3.IT-7.7	Urgent dental care needs in older adults	
City of Lubbock, Health Department		**135103304**	
Related Category Project:	**135103304.1.2**		
Starting Point/Baseline:	**To be determined in DY3**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans. **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $15,639.47	**Process Milestone 2: P-2** Establish baseline rates **Data Source:** PP Utilization Data, Clinic Utilization Data **Milestone 2 Estimated 1 Incentive Payment:** $34,707.85	**Outcome Improvement Target 1:** **IT7.7:** Urgent dental care needs in older adults **Improvement Target:** Decrease the number of older adults 65 years or older with urgent dental care needs by 10% from baseline **Data Source:** PP Utilization Data, Clinic Utilization Data **Estimated Outcome Improvement Target 1 Incentive Payment:** $35,333.49	**Outcome Improvement Target 2:** **IT7.7:** Urgent dental care needs in older adults **Improvement Target:** Decrease the number of older adults 65 years or older with urgent dental care needs by 15% from baseline **Data Source:** PP Utilization Data, Clinic Utilization Data **Estimated Outcome Improvement Target 2 Incentive Payment:** $73,848.93
DY 2 Estimated Outcome Amount: $15,639	***DY 3 Estimated Outcome Amount:*** $34,708	***DY 4 Estimated Outcome Amount:*** $35,333	***DY 5 Estimated Outcome Amount:*** $73,849
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $159,530			

Outcome Measure Title: IT-1.7 Controlling High Blood Pressure

Performing Provider: Cogdell Memorial Hospital/1366330107

RHP Outcome Identification Number: 136330107.3.1

Outcome Domain: OD-1 Primary Care and Chronic Disease Management

Outcome Measure Description:

IT-1.7 Controlling High Blood Pressure

Due to the number of patients, approximately 1,500 and the ones who have not been diagnosed estimated to be as much as two times the number who have been diagnosed with Uncontrolled Blood Pressure, CMH has chosen this Category 3 project to go along with its Category 1.1.2 project. We fill this will work very nicely with a walk-in clinic and increased providers, especially a Hispanic physician, will allow the organization to reach out and get more patients to come in and get tested.

Process Milestones:

- **DY1**
  - **P-1** Project planning – engage stakeholders, identify current capacity and needed resources determine timelines and document implementation plans.
- **DY2**
  - **P-2** Establish baseline

Outcome Improvement Target(s):

- **DY3**
  - **IT-1.7 Controlling High Blood Pressure**

- Work to get all patients in the service area to get regular blood pressure checks in order to determine all patients with uncontrolled hypertension. Once a patient gets their blood pressure checked at one of the places CMH will set up, they will be able to schedule an appointment if their blood pressure is found to be high or borderline high. Work to get the at least 100-150 of current patients with uncontrolled blood pressure doing routine checks and attempt to get another 500-1,000 who have not been diagnosed on board. CMH feels there are numerous, approximately 1,500 patients who have this issue and will attempt to get 10% under control in DY 3.

o **DY4**

- **IT-1.7 Controlling High Blood Pressure**
- Work to get another 10% or 100-150 patients from baseline of those with uncontrolled blood pressure under provider care and get their blood pressure back in line.

CMH will review all patients who have blood pressure issues and work with them to ensure they are monitoring their blood pressure on a regular basis and find ways for these patients to have a blood pressure machine at home as well. Also, CMH will develop programs to educate patients on symptoms of high blood pressure and work with local pharmacy indigent program to ensure those who cannot afford the medication can get it. CMH's goal by the end of the waiver period will be to have 75% of patients with uncontrolled high blood pressure and getting and maintaining proper treatment.

Rationale: The reason for the selection is because the heart attacks and strokes affect every one of us in some way. CMH will be able to attract more of the Hispanic patients by recruiting a Hispanic physician and provide blood pressure screening stations in the community at various locations. This will allow patients and CMH to be able to work towards addressing those patients with high blood pressure. The goal in DY4 is to reduce those who have uncontrolled blood pressure by 50% and in DY5 reduce it another 25%.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves	By getting the patients in more timely, or by third next available, we will be able to get patients seen earlier, provide more timely	5

Waiver Goals	diagnosis and treatment, improve the patients recovery and help reducing the re-occurring cost because patients have taken so long to be seen. Also, by using case mgmt. to call patients after they leave the hospital to ensure they followed up with their primary care physician, we will ensure patients are maintaining the treatment prescribed by the physicians. We will improve the overall health of the our population including the Medicaid and uninsured patients by developing these process as well by qualifying more patients for charity and indigent which will allow those to get treatment more timely and not worry about payments or only a small copay. This will further develop and maintain a coordinated care delivery system between the hospital, clinic and outlying regional hospitals. Outcomes will improve thru these processes at the same time, reducing cost or maintaining cost because patients will be treated more timely. This project will work together with Cat 1 & 2 projects 1.1.2 and 2.3.1 The project will affect all patients but will improve the Medicaid and uninsured ability to get in and get seen by a provider and get a treatment going timelier. The impact is significant by reducing ER non-emergent visits, adding more providers to see more patients, offering different alternatives to patients for primary care as well as being able to offer more services. In looking at the different literature reviews, best practices, and/or past experience, the effect of this project will help reduce readmissions, preventable admissions, non-emergent ER visits.	
Addresses Community Need(s)	The project will help address the need for more providers due to the fact we are in a HPSA, it addresses the need in the community to help those who cannot afford to pay for healthcare, it gives the community a better process and more timely access to care The impact is significant not only to CMH, but to regional hospitals by not having patients get transferred because their illness has gotten so severe they need the assistance of a tertiary hospital, it reduces EMS cost.	5
Project Scope/Size	This project will reach our entire population, including the Medicaid and uninsured Patient visits/encounters – the project should help increase patient visits by over 20% in the waiver period Providers recruited/trained – 3 physicians and possibly 2-3 Pas/NPS Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations $391,833	5
Project Investment	There will be an additional 10-15 staff added for direct patient care and even more overhead staff The building of a new clinic, which includes a walk-in clinic will be a substantial investment along with the development of a central scheduling department Legal and professional fees will be pretty expensive to ensure all things are done right Time to implement during the waiver period, with the clinic coming on line in 2014 and physicians being recruited each year thru 2015 This is a top organizational priorities by the hospital district board and administration for the next several years.	5

136330107.3.1	IT 17	Controlling High Blood Pressure IT-1.7	
Cogdell Memorial Hospital		136330107	
Related Category 1 or 2 Project(s):	136330107.1.1		
Starting Point/Baseline:	Baseline TBD		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013 9/30/2014)	DY 4 (10/1/2014-9/30/2015)	DY5 (10/1/2015-9/30/2016)
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of Planning and Stakeholder Engagement Process Milestone 1 Estimated Incentive Payment: $46,278	**Process Milestone 2** P- 2 Establish baseline rates Data Source: EMR/Registry Process Milestone 2 Estimated Incentive Payment: $53,643	Outcome Improvement Target 1: [IT-1.7] Controlling High Blood Pressure Improvement Target: Reduce number of patients with uncontrolled blood pressure by 10% or 100-150 patients from base line Data Source: EHR Records Estimated Outcome Improvement Target 1 Incentive Payment: $86,076	**Outcome Improvement Target 2: [IT-1.1] Third Next Available appointment** Improvement Target: Reduce number of patients with hypertension by another 10% or a total of 200-300 patients from base line Data Source: EHR Records Estimated Outcome Improvement Target 2 Incentive Payment $205,836
DY 2 Estimated Outcome Amount: $46,278	**DY 3 Estimated Outcome** Amount: $53,643	**DY 4 Estimated Outcome Amount:** $86,076	**DY 5 Estimated Outcome Amount:** $205,836
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YE**AR PERIOD:** $391,833			

Project Title: IT-12.1 Breast Cancer Screening

Performing Provider: Cogdell Memorial Hospital/136330107
RHP Outcome Identification Number: 136330107.3.2

Outcome Domain: OD-12 Primary Care and Primary Prevention

Outcome Measure Description:

IT-12.1 Breast Cancer Screening

Number of women age 40- to 69 that have received an annual mammogram during the reporting period.

Process Milestones:

- **DY1**
  - **P-1** Project planning – engage stakeholders, identify current capacity and needed resources determine timelines and document implementation plans.

- **DY2**
  - **P-2** Establish baseline

Outcome Improvement Target(s):

- **DY3**
  - **IT-12.1 Breast Cancer Screening**
    - Number of women age 40- to 69 that have received an annual mammogram during the reporting period
- **DY4**
  - **IT-12.1 Breast Cancer Screening**
    - Number of women age 40- to 69 that have received an annual mammogram during the reporting period

CMH will develop a program in conjunction with the community to help women get routine mammos for breast cancer screening. The ultimate goal is 100% of all women in the right age and medical history get this, but realistically, CMH is trying to get at least 75%. Currently about 45-50% of our population identified who needs an annual screening exam are getting them.

Rationale: The reason for the selection is because breast cancer affects so many lives and almost every one of us knows someone who has been diagnosed with it. It is an easy exam and the hospital will work with the radiologists to offer special prices during the year so women can afford the screening exam. FY 2 goal is to get 60% of the population to get the test and in FY 3, 65%.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	By increasing the number of patients getting their annual breast cancer screenings, it will improve the quality of the patient's life, help reduce healthcare cost and provide a very effective means of getting patients with colon cancer caught at a very early stage. It will improve the infrastructure to better serve the underserved population This will be a community project which will develop the coordination among the population and CMH as well as other healthcare providers in the region The project will improve patient outcomes at the same time by doing the screening exams it will be at minimum cost. The project will target the entire population but it will work with local charities to find funding for those who cannot afford these	**5**
Addresses Community Need(s)	The project will address a major need and by doing this and the other cat 3 milestone 12 projects they combined will address major needs The impact will be significant in regards to the patients' health and the ability to catch things faster There is very strong evidence and protocols which recommend these test annually.	**5**
Project Scope/Size	Outreach to the targeted population - yes it will reach its targeted population with the chance of even greater population Patient visits/encounters - N/A, number of screenings to increase by over 15% during the waiver period Providers recruited/trained – none, already have in community Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations $130,000	**5**

Project Investment	Human resources - moderate Equipment purchase and maintenance - large investment required to ensure annual screening exams and large maintenance to keep digital mammo up and going Legal and professional fees, large potential for legal and professional fee annually Time to implement - about a 2 years to get up and going fully Risk assessment – significant risk Organizational priorities - major priority	**5**

136330107.3.2	3.IT.12.1	Breast Cancer Screening IT-12.1	
Cogdell Memorial Hospital		136330107	
Related Category 1 or 2 Project(s):	136330107.2.1		
Starting Point/Baseline:	**Baseline TBD**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of Planning and Stakeholder Engagement **Process Milestone 1 Estimated Incentive Payment***:* $15,426	**Process Milestone 2** P- 2 Establish baseline rates Data **Source: EMR/Registry** **Process Milestone 2 Estimated Incentive Payment:** $17,881	***Outcome Improvement Target 1: [IT 12.] Breast Cancer Screening*** ***Improvement Target:****70% or an increase of 5%* **Data Source:** Hospital records and community assessment to determine base population **Estimated Outcome Improvement Target 1 Incentive Payment** *$28,692*	***Outcome Improvement Target 2: [IT-1.12] Breast Cancer Screening*** **Improvement Target:***75% or 5% increase* **Data Source:** Hospital records and community assessment to determine base population **Estimated Outcome Improvement Target 2 Incentive Payment** *$68,612*
DY 2 Estimated Outcome Amount: *$15,426*	***DY 3 Estimated Outcome Amount****:* *$17,881*	***DY 4 Estimated Outcome Amount:*** *$28,692*	***DY 5 Estimated Outcome Amount:*** *$68,612*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* *$130,611*			

Project Title: IT-12.3 Colorectal Cancer Screening

Performing Provider: Cogdell Memorial Hospital/136330107

RHP Outcome Identification Number: 136330107.3.3

Outcome Domain: OD-12 Primary Care and Primary Prevention

Outcome Measure Description:

IT-12.3 Colorectal Cancer Screening

The Screenings will be measured by the number of adults age 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexibly sigmoidoscopy every five years, colonoscopy every 10 years.

Process Milestones:

- **DY1**
  - **P-1** Project planning – engage stakeholders, identify current capacity and needed resources determine timelines and document implementation plans.

- **DY2**
  - **P-2** Establish baseline

Outcome Improvement Target(s):

- **DY3**
  - **IT-12.3 Breast Cancer Screening**
    - Number of adults age 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexibly sigmoidoscopy every five years, colonoscopy every 10 years.
- **DY4**
  - **IT-12.3 Breast Cancer Screening**
    - Number of adults age 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexibly sigmoidoscopy every five years, colonoscopy every 10 years.

CMH will develop a program in conjunction with the community to help patients get routine PSA's for colorectal cancer screening in conjunction with the colonoscopy at the required times. The ultimate goal is 100% of all patients in the right age and medical history get this, but realistically, CMH is trying to get at least 65%. Currently, CMH has seen about 45% of the population who need to be having this exam annually are actually doing so.

Rationale: The reason for the selection is because colon cancer affects so many lives and almost every one of us knows someone who has been diagnosed with it. CMH will work with the Internal Medicine physician who does colonoscopies and the lab to develop a program which makes each test affordable and develop some resource for those who cannot afford the test. FY 2 goal is to get 50% of the population to get the test and in FY 3, 60%. By getting patients to adhere to annual screenings, any type of colon cancer can be caught early on and help reduce the cost of healthcare at the same time, extend the patients live and their health.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	By increasing the number of patients getting their annual colon cancer screenings, it will improve the quality of the patient's life, help reduce healthcare cost and provide a very effective means of getting patients with colon cancer caught at a very early stage. It will improve the infrastructure to better serve the underserved population This will be a community project which will develop the coordination among the population and CMH as well as other healthcare providers in the region The project will improve patient outcomes at the same time by doing the screening exams it will be at minimum cost The project will target the entire population but it will work with local charities to find funding for those who cannot afford these services	**5**
Addresses Community Need(s)	The project will address a major need and by doing this and the other cat 3 milestone 12 projects they combined will address major needs The impact will be significant in regards to the patients' health and the ability to catch things faster There is very strong evidence and protocols which recommend these test annually.	**5**
Project Scope/Size	Outreach to the targeted population - yes it will reach its targeted population with the chance of even greater population Patient visits/encounters - N/A, number of screenings to increase by over 15% during the waiver period Providers recruited/trained – none, already have in community Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations $130,000	**5**
Project Investment	Human resources - moderate Equipment purchase and maintenance - large investment required to ensure annual screening exams Legal and professional fees, large potential for legal and professional fee annually Time to implement - about a 2 years to get up and going fully Risk assessment – significant risk Organizational priorities - major priority	**5**

136330107.3.3	3.IT-12.3	Colorectal Cancer Screening	
Cogdell Memorial Hospital		136330107	
Related Category 1 or 2 Project(s):	136330107.2.1		
Starting Point/Baseline:	TBD		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	
Process Milestone 1 **P- 1** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of Planning and Stakeholder Engagement **Process Milestone 1 Estimated Incentive Payment:** $15,426	**Process Milestone 2** **P- 2** Establish baseline rates **Data Source:** EMR/Registry **Process Milestone 2 Estimated Incentive Payment:** $17,881	**Outcome Improvement Target 1: IT 12.3 Colorectal Cancer Screening** **Improvement Target:** up the percentage another 5% to 60% **Data Source:** Hospital Records, state records and community needs assessment **Estimated Outcome Improvement Target 1 Incentive Payment:** $28,692	**Outcome Improvement Target 2: IT 12.3 Colorectal Cancer Screening** **Improvement Target:** up the percentage another 5% to 65% **Data Source:** Hospital Records, state records and community needs assessment **Estimated Outcome Improvement Target 3 Incentive Payment:** $68,612
DY 2 Estimated Outcome Amount: $15,426	**DY 3 Estimated Outcome Amount:** $17,881	**DY 4 Estimated Outcome Amount:** $28,692	**DY 5 Estimated Outcome Amount:** $68,612
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $130,611			

Project Title: IT-12.4 Pneumonia vaccination status for older adults

Performing Provider: Cogdell Memorial Hospital/136330107

RHP Outcome Identification Number: 136330107.3.4

Outcome Domain: OD-12 Primary Care and Primary Prevention

Outcome Measure Description:

IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012) (Non-standalone measure)

- **Number of adults aged 65 and older that have ever received a pneumonia vaccine.**

Process Milestones:

- **DY1**
  - **P-1** Project planning – engage stakeholders, identify current capacity and needed resources determine timelines and document implementation plans.

- **DY2**
  - **P-2** Establish baseline

Outcome Improvement Target(s):

- **DY3**
  - **IT-12.4 Pneumonia vaccination status for older adults**
    - Number of adults aged 65 and older that have ever received a pneumonia vaccine.
- **DY4**
  - **IT-12.4 Pneumonia vaccination status for older adults**
    - Number of adults aged 65 and older that have ever received a pneumonia vaccine

12.4 CMH will develop a program in conjunction with the community to help patients get their pneumonia vaccinations when they reach the age of 65 as well as with any patients already 65 or older who have not received their pneumonia vaccinations. The ultimate goal is 100% of all patients in the right age and medical history get this, but realistically, CMH is trying to get at least 80%. Currently, CMH has seen about 55% of the population who need to have this vaccination are actually getting it.

Rationale: 12.4 CMH the reason for the selection is because pneumonia affects so many elderly patients each year and it can be treated and the effects of it can be reduced along with the need for hospitalization if the pneumonia vaccination is administered to these patients and other high risks patients. CMH will work with the their physicians and clinic staff as well as hospital nursing to develop a program which makes the pneumonia vaccination part of the annual checklist to ensure the patients who have missed this received it. FY 3 goal is to get 70% of the population to get the test and in FY 3, 80%.

Outcome Measure: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	By increasing the number of patients getting their pneumonia vaccination, it will reduce the risk of the elderly patient getting pneumonia and improve the quality of the patient's life, help reduce healthcare cost and provide a very effective means of getting patients with colon cancer caught at a very early stage. It will improve the infrastructure to better serve the underserved population This will be a community project which will develop the coordination among the population and CMH as well as other healthcare providers in the region The project will improve patient outcomes at the same time The project will target the entire population but it will work with local charities to find funding for those who cannot afford these services	**5**
Addresses Community Need(s)	The project will address a major need and by doing this and the other cat 3 milestone 12 projects they combined will address major needs The impact will be significant in regards to the patients' health and the ability to catch things faster There is very strong evidence and protocols which recommend this vaccination for the elderly population and with the baby boomer population growing it is very important to catch the patient when they turn 65 and not wait for several years.	**5**
Project Scope/Size	Outreach to the targeted population - yes it will reach its targeted population with the chance of even greater population Patient visits/encounters - N/A, number of screenings to increase by over 15% during the waiver period Providers recruited/trained – none, already have in community Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations $130,000	**5**

Project Investment	Human resources - moderate Equipment purchase and maintenance - large investment required to ensure IT infrastructure in place via an EMR to capture these paitents. Legal and professional fees, large potential for legal and professional fee annually Time to implement - about a 2 years to get up and going fully Risk assessment – significant risk Organizational priorities - major priority	**5**

136330107.3.4	IT 12.4	IT-12.4 Pneumonia vaccination status for older adults	
Cogdell Memorial Hospital		136330107	
Related Category 1 or 2 Project(s):	136330107.2.1		
Starting Point/Baseline:	**TBD**		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of Planning and Stakeholder Engagement **Process Milestone 1 Estimated Incentive Payment (maximum amount):** $15,426	**Process Milestone 2** P- 2 Establish baseline rates **Data Source:** EMR/Registry **Process Milestone 2 Estimated Incentive Payment:** $17,881	**Outcome Improvement Target 1: IT 12.4** Pneumonia vaccination status for older adults **Improvement Target:** Increase the number of people getting pneumonia vaccinations by over 10% **Data Source:** Hospital Records, state records and community needs assessment **Estimated Outcome Improvement Target 1 Incentive Payment:** $28,692	**Outcome Improvement Target 2: IT 12.4** Pneumonia vaccination status for older adults **Improvement Target:** Increase the number of people getting pneumonia vaccinations by over 10% **Data Source:** Hospital Records, state records and community needs assessment **Estimated Outcome Improvement Target 3 Incentive Payment:** $68,612
DY 2 Estimated Outcome Amount: $15,426	**DY 3 Estimated Outcome Amount:** $17,881	**DY 4 Estimated Outcome Amount:** $28,692	**DY 5 Estimated Outcome Amount:** $68,612
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $130,611			

Outcome Measure Title: IT 2.1 Congestive Heart Failure Admission Rate
Performing Provider: Cogdell Memorial Hospital/136330107
Unique Outcome ID: 136330107.3.6 – **"PASS 3B"**

- Outcome Measure Description: By enhancing our performance improvement systems and reporting CMH will be able to work in coordination will all of its service and the community to develop a process to ensure patients are staying on the designed treatment plan and thus reducing the need for admission to the hospital for CHF. Currently, CMH has approximately 100 CHF admissions a year and with proper education and training to the staff thru the development of a process improvement team we will be able to reduce the number of CHF admissions by ensuring the patients diagnosed with CHF are following their prescribed treatment plans when they are at home as well as ensuring they are following up with their primary care provider. Our goals will to be focus on those patients with the highest potential to get CHF to determine, thru process improvement team, ways to ensure they are compliant in their treatment plan and they also have timely access to primary care and ancillary services. We will also train and educate our clinical staff on ways to recognize when a patient is retaining fluid and how to address the situation. We will also create reports to show where we are when it comes to CHF admissions and compare to the past and where we stand in meeting our goals. This report will go to all clinical staff, physicians, our QAPI team and the board. We will give our physicians a report showing how many CHF admissions they have and thru this, we will work with them to address the issues of why the patient got admitted and implement a process improvement team to work on potential preventable admissions. This team will be able to develop a coordinated effort among the hospital departments to ensure proper and timely follow up on CHF patients thru our ability to collect and analyze data, the reports generated from this data and our development of train the trainer process.
  - Improvement Target Description: CHF Admission Rate
  - Process Milestones:
    - DY2: Begin coordinated efforts among hospital departments to develop process to ensure properly and timely follow up on CHF patients thru better collecting and analyzing of data collected in our QAPI and development of train the trainer process
    - DY3 With the increase in staff in QI and increased collection of quality measures, we will be able to identify those patients who need follow up and address issues on the Potentially Preventable Admissions
  - Outcome Improvement Targets for each year:
    - DY4 Reduce CHF Admission Rates by 10% or 10 admissions
    - DY5 Reduce CHF Admission Rates by another 10% or 20 total admissions from base line

- Rationale: The project option chosen by CMH is IT 12.1 which is the reduction of CHF Admission Rates. It is very critical to its community and its ability to provide services which are needed by the employees, patients and the community. In project IT 12.1, CMH will develop or enhance its quality improvement process to come up with a plan to address CHF Admissions and potential preventable admissions for CHF through coordinated efforts with the hospital departments and primary care providers. Thru enhancing our performance improvement systems and reporting CMH will be able to work in coordination will all of its service and the community to develop a process to ensure patients are staying on the designed treatment plan and thus reducing the need for admission to the hospital for CHF. Currently, CMH has approximately 100 CHF admissions a year and with proper education and training to the staff thru the development of a process improvement team we will be able to reduce the number of CHF admissions by ensuring the patients diagnosed with CHF are following their prescribed treatment plans when they are at home as well as ensuring they are following up with their primary care provider. Our goals will to be focus on those patients with the highest potential to get CHF to determine, thru process improvement team, ways to ensure they are compliant in their treatment plan and they also have timely access to primary care and ancillary services. We will also train and educate our clinical staff on ways to recognize when a patient is retaining fluid and how to address the situation. We will also create reports to show where we are when it comes to CHF admissions and compare to the past and where we stand in meeting our goals. This report will go to all clinical staff, physicians, our QAPI team and the board. We will give our physicians a report showing how many CHF admissions they have and thru this, we will work with them to address the issues of why the patient got admitted and implement a process improvement team to work on potential preventable admissions. This team will be able to develop a coordinated effort among the hospital departments to ensure proper and timely follow up on CHF patients thru our ability to collect and analyze data; the reports generated from this data and our development of train the trainer process. In doing this, CMH will show process milestones of P-1, P-4, and IT I.1.

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	In order to accomplish the reduction in hospital admissions for CMH, there will need to be a coordinated effort among all hospital settings, increase in primary care providers, and setting realistic goals to ensure this project will increase the health of those patients with CHF, ensure they stay on treatment levels, work with the local pharmacy indigent program to ensure they receive their medications as well as take them timely.	**5**
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: This project will meet the needs of the community and those who have CHF no matter what insurance or what race. It will be important to work with this program to ensure better care and follow up.	**5**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in The intent is to reach the entire CHF population and those who have the risks factors for it and address those early on thru education, proper training and more accessibility to care with a good follow up process.	**5**
Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: This is a top priority and it will require extensive resources in order to be accomplished.	**5**

136330107.3.6 – "PASS 3B"	***IT 2.1***	***IT 2.1 Congestive Heart Failure Admission Rate***	
Cogdell Memorial Hospital			***136330107***
Related Category 1 or 2 Projects: 1	***136330107.13***		
Starting Point/Baseline:	***TBD***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Develop process to coordinate all levels of service to work with patients in all settings including home Data Source: Policy Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $48,099	**Process Milestone 3** P- 2 Establish baseline rates **[P-4] Recruit more QI staff to help train the hospital employees and provide annual orientation on the importance of QAPI.** Data Source: **Hospital employment records** Process Milestone 2 Estimated Incentive Payment: $53,372	**Outcome Improvement Target 1** [IT-1.1]: Reduce Hospital CHF Admission Rates by 10% Improvement Target: TBD, we expect a 10% reduction or 10 admissions from the baseline, established in DY 3. Data Source: Hospital Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $81,501	**Outcome Improvement Target 2** [IT-1.1]: Improvement Target: TBD, we expect to reduce CHF Admissions by 20% or 20 admissions from the baseline. Data Source: Hospital Records Outcome Improvement Target 2Estimated Incentive Payment*:* $187,376
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,099	Year 3 Estimated Outcome Amount: $53,372	Year 4 Estimated Outcome Amount: $81,501	Year 5 Estimated Outcome Amount: $187,376
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $370,348			

Title of Outcome Measure: IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores

Performing Provider: Dallam - Hartley County(s) Hospital District dba Coon Memorial Hospital/130826407

Unique RHP Outcome Identification number: 130826407.3.1

Outcome Measure Description:

IT-6.1-Percent Improvement over Baseline of Patient Satisfaction Scores

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool

Process Milestones:

- DY2:

P-1 – Project Planning-Engage Stakeholders, Identify current Capacity & Needed Resources, Determine Timelines & Document Implementation Plans

P-3 – Develop & Test Data Systems

- DY3:

P-2 – Establish Baseline Rates

P-4 – Conduct (PDSA) Cycles To Improve Data Collection

Outcome Improvement Targets For Each Year:

- DY4:

IT-6.1 Improvement over Baseline Established In DY3 Of 5% For Each (1) Getting Timely Care, (2) Appointments And (3) Information.

- DY5:

IT-6.1 Improvement over Baseline Established In DY3 Of 10% For Each (1) Getting Timely Care, (2) Appointments And (3) Information.

Rationale:

The rationale for the patient satisfaction scores is to improve our existing processes in the primary care clinic as well as integrate additional primary care physicians/ practitioners over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient. Currently, there is no method or

process in place to measure patient satisfaction within our clinic.
The milestone for DY 2 is to identify a method/company/software to gather data on a patient getting timely care, appointments, and information. DY 3 milestone is the implementation of the tool to gather the information from patients on how timely their care was, how easy it is to obtain an appointment, the quality of the information given and if they felt their physician or practitioner communicated with them adequately. DY 3 implementation process will set baseline data for DY 4 and DY 5 comparisons. DY 4 improvement target is to improve patient satisfaction scores for timely care, appointments, information and physician/practitioner care by 5% over baseline. DY 5 improvement target is to improve patient satisfaction scores for timely care, appointments, information and physician/practitioner care by 10% over baseline.
Within the RHC (Dalhart Family Medicine Clinic) of Dallam-Hartley County(s) Hospital Districts dba Coon Memorial Hospital, it is our belief that focusing on what patient's expect in their scope of care experience is fundamental to the improvement of clinical outcomes, compliance & quality. The adoption/Implementation of the CG CAHPS survey will provide subsequent reporting measures that will enable our district to meet with staff & Providers to evaluate enhancements that continually improve upon the metrics that effect our Healthcare establishment, and most importantly, our Patient's.

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	The goal of CMH is to continually strive toward the improvement of the patient experience and is an institutional priority: our ability to accomplish this metric is impaired by inadequate tools and data. DHCHD's commitment to improving the patient's experience of care is embedded in its overall strategic plan. Our DSRIP measure plan is to contract with the nationwide survey system (CG-CAHPS) to provide us the data necessary to continually evaluate and implement design that will ultimately benefit the patient experience as well as the patient's health status/health function, outcome. We intend to increase the organization's capacity to improve patients' experience of care and meet their satisfaction with the care provided. This will be accomplished by implementing new tools and contract the necessary (CA CAHPS). In addition, internal display and sharing of data will give staff the tools and information necessary to take progressive steps to promote performance improvement.	**5**

Addresses Community Need(s)	The Scope of this is Relative to the outreach to our Patient's whom reside in both District's that we serve. This is our targeted population, which is at this time, underserved. Our patient data of the analysis is at an average of #35% Medicaid, 29% Medicare. Our patient encounters, with 3 primary care providers & 1 mid level PA was at #20,000+. Our goal is to maintain access for our community. Dallam/Hartley Counties are nationally recognized as a Health Provider Shortage Area (HPSA) so the recruitment and retention of new and existing primary care providers is an imperative for the county and the region. The greatest healthcare challenge faced by Dallam-Hartley County(s) and the region is the shortage of primary care physicians nationwide with the gap of what is needed and supplied widening. According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. More primary care physicians are a badly needed asset for the present and the future of RHP Region 12 rural communities. The most glaring evidence of the challenges facing rural communities in Region 12 is the number of primary care practitioners currently providing services to our population. In 2007, the state ratio of total persons to each direct patient care and primary care physician was 386. In comparison the ratio is 991.1 residents per direct patient care and primary care physician for Region 12. Currently in Dallam/Hartley Counties, according to the 2010 census, the population is 12,765. With the current number of primary care physicians and practitioners that translates to a ratio of 3191 persons to every primary care physician and practitioner. The implementation of the patient satisfaction survey for clinic patients will help ensure that the patients seeking primary healthcare in the clinic will have their needs and expectations met.	**5**
Project Scope/Size	This Category 3 project in improving patient satisfaction ranks second in the benefit to primary care expansion (Category 1 Project). The targeted population will not only realize the benefits to easier access to primary care, but also receiving the most value for their healthcare dollar. The targeted population will be the patients utilizing the clinic which will increase with the addition of three more primary care physicians and practitioner to the clinic. Patient will also be more able to avoid seeking primary healthcare outside of the clinic, because of the availability of additional practitioners.	**5**
Project Investment	The investment in this project is an estimate at of around $558,165. DY 2 will have the upfront initial investment of searching and testing the myriad of survey options to determine the most economical method to obtaining the required baseline data. No more than $73,196 will be utilized in determining the method for data collection from patient satisfaction surveys. DY 3 will have an investment of no more than $99,238 to develop a baseline for the surveys. DY4 will be the first full year of data collection that will be used to improve healthcare value as well as patient satisfaction. No more than $135,358 will be invested in DY 3. In the last year of the project, DY 4, the investment for the project will increase to no more than $250,373. The increase in investment is attributed to the success of the Category 1 project and the addition of a primary care physician/practitioner & staffing.	**5**

130826407.3.1	3.IT-6.1		Percent Improvement over baseline of Patient Satisfaction
Dallam-Hartley Counties Hospital Districts dba Coon Memorial Hospital		130826407	
Related Category 1 or 2 Project(s):	130826407.1.1		
Starting Point/Baseline: No Baseline At This Time	**To be determined**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: {P-1} Project Planning-Engage Stakeholders, Identify current Capacity & Needed Resources, Determine Timelines & **Data Source:** Document Implementation Plans. **Process Milestone 1 Estimated Payment:** $21,403.50 **Process Milestone 2:** {P-3} – Develop & Test Data Systems **Data Source:** Coon Memorial Hospital **Process Milestone 2 Estimated Incentive Payment:** $21,403.5	**Process Milestone 3:** {P-2} Establish Baseline Rates **Data Source:** Survey Tool **Process Milestone 3 Estimated Incentive Payment:** $24,809.50 **Process Milestone 4:** {P-4} Conduct (PDSA) Cycles To Improve Data Collection (Implement patient satisfaction gather option) **Data Source:** Coon Memorial Hospital **Estimated Milestone 2 Incentive Payment:** $24,809.50	**Outcome Improvement Target 1: [IT-6.1]** Percent Improvement over baseline of Patient Satisfaction Scores **Improvement Target: Improvement** over baseline established in DY3 of 5% for each (1) getting timely care, (2) appointments, and (3) information. **Data Source:** Survey Tool Selected in DY 2 **Estimated Outcome Improvement Target 2 Incentive Payment:** $79,621	**Outcome Improvement Target 2: [IT-6.1]** Percent Improvement over baseline of Patient Satisfaction Scores **Improvement Target:** Improvement over baseline established in DY3 of 10% for each (1) getting timely care, (2) appointments, and (3) information. **Data Source:** Survey Tool Selected in DY 2 **Estimated Outcome Improvement Target 3 Incentive Payment:** $190,398
DY 2 Estimated Outcome Amount: $42,807	**DY 3 Estimated Outcome Amount:** $49,619	**DY 4 Estimated Outcome Amount:** $79,621	**DY 5 Estimated Outcome Amount:** 190,398
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$362,445*			

Title of Outcome Measure: IT-7.2 Cavities: Percentage of Children With Untreated Dental Caries (Healthy People 2020)
Performing Provider: Dallam Hartley Counties Hospital District dba Coon Memorial Hospital/130826407
Unique RHP Outcome Identification number: 130826407.3.3 – "PASS 3b"

- **Outcome Measure Description:** **IT-7.2** Cavities: Percentage of Children With Untreated Dental Caries (Healthy People 2020) Our Outcome Measure Is To Gather Data For Access To Further Provide Oral Healthcare Within Our District & Community To Children, Ages 2-19, That Are Currently Unable To Receive This Treatment Due To Circumstance Of Any Dentist Within 96 Miles That Will Perform Treatment To Those That Are Low Income, Under Insured, Indigent Or Are On Medicaid Assistance. The Outcome Of Process Monitoring Will Enable Our Hospital District & Rural Health Clinic To Meet These Needs Efficiently And Provide Oral Healthcare By Means Of Data. This Will Enable Our Community & District To Refer Within & Escalate The Improvement Target By 20% By The End Of DY5.
    - Improvement Target Description: Decrease The Percentage Of Children With Untreated Dental Caries
    - Process Milestones:
        - **DY2:**
            - **P-1 -** Project Planning. Gather Data From The Past #2 Years To Establish Baseline Reporting. Create a Process To Monitor And Assess Needs.
            - **P-**2 – Establish a Basline
            - **P-3 -** Develop & Test data systems
        - **DY3:**
            - P-4 – Conduct Plan Do Study Act (PDSA) cycle to improve data collection and intervention activities. Implement Systematic Data For Capturing Need Assessments For Oral (Cavity) Treatment Within Our Community By Reporting Measures On Patient Visits, Early Childhood Intervention, Well Child Check-Ups & Emergency Room Visits Within The Rural Health Clinic (Dalhart Family Medicine Clinic as well as Coon Memorial Hospital).
    - Outcome Improvement Targets for each year:
        - **DY4:**
            - IT-7.2 Decrease the Percentage of Children with Untreated Dental Caries by 7.5%
        - **DY5:**
            - IT-7.2 Decrease the Percentage of Children with Untreated Dental Caries by an additional 12.5%

- Rationale: Oral Health Is Essential To Overall Health. We Must Initiate Methods To Improve Monitoring & Evaluating Oral Health & Conditions. The CDC Reports The Most Recent Period Shows High Levels Of Untreated Cavities: 19.5% In Children Ages 2-5 And 22.9% In Children 6-19. Our District Is Currently Unable To Provide This Service To Medicaid, Underinsured, Non-Insured/Low Income Children, As We Do Not Have A Dentist That Provides Services To These Children Within This Criteria. This process milestone was chosen due to lack of accurate reports, access to information, and current providers and infrastructure are non-existent.

  Prevalence: 42% Of Children Have Had Dental Caries In Their Primary Teeth. Black & Hispanic Children & Those Living In Families With
  Lower Incomes Have More Decay. Unmet Needs: 23% OF Children 2-11 Have Untreated Dental Care. Black & Hispanic Children & Those
  Living In Families With Lower Incomes Have More Untreated Decay.[

  As we Are Linking This Category #3 Project With the Submission of Our Category #1 Project 1.8.6, We Will Establish Dental Services Aimed At These Individual (Above Mentioned). With The Utilization Of Data collection, Monitoring & Reporting, It Is Our Primary Goal To Achieve An Outcome That Provides Our District & Community With A Means Of Obtaining Oral Healthcare. With The Milestone & Measures Targets Listed In DY2-5, Our Goal Is To Increase Our Outcome Improvement By 20% For Cavity Intervention & Oral Healthcare Within The Population Of Our Children.

  Related Category 1 Project: Category 1 Project 1.8.6; 130826407.1.8.6 The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.

Outcome Measure Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: • Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways • Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties • Further develop and maintain a coordinated care delivery system • Improve outcomes while containing cost growth Performing Providers may consider the following attributes when scoring projects on this domain:	**1-5**

	• Will the project impact one or more of the goals? • Does the project primarily impact Medicaid and/or uninsured residents? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: • Will the project address one or more community need? • How significant is the expected impact? To what extent will it "move the dial"? • Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?	**1-5**
Project Scope/Size Scale: 1 to 5	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in • Outreach to the targeted population • Patient visits/encounters • Providers recruited/trained Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**1-5**
Project Investment Scale: 1 to 5	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: • Human resources • Equipment purchase and maintenance • Legal and professional fees • Time to implement • Risk assessment • Organizational priorities	**1-5**

130826407.3.3 – "PASS 3b"	*3.IT-7.2*	*Cavities: Percentage of children with untreated dental caries*	
Dallam-Hartley Counties Hospital Districts dba Coon Memorial Hospital			*130826407*
Related Category 1 Project	130826407.1.3		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: {P-1} Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Planning Documentation **Process Milestone 1 Estimated payment:** $14,587.66 **Process Milestone 2:** {P-2} Establish Baseline **Data Source:** Coon Memorial **Process Milestone 2 Estimated payment:** $14,587.66 **Process Milestone 3:** {P-3}Develop and Test data systems **Data Source:** Test System logs **Process Milestone 3 Estimated payment:** $14,587.66	**Process Milestone 4:** {P-4}Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Coon Memorial Hospital **Estimated Incentive Payment*:*** $55,035	**Outcome Improvement Target 1: [IT-7.2]** Cavities: Percentage of children with untreated dental caries **Improvement Target 1:** Of Oral Health. Structure Our EHR & Referral Process(s) To Capture Data & Integrate Practices That Bear a 7.5% Improvement Target Within Our District For Cavity Intervention. **Data Source:** Survey Tool Selected in DY 2 **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $65,914	**Outcome Improvement Target 2:** **[IT-7.2]** Cavities: Percentage of children with untreated dental caries **Improvement Target 2:** Show A Marked Improvement of Established Oral Health Reporting Of An Additional 12.5% Improvement Above Baseline. **Data Source:** Survey Tool Selected in DY 2 **Outcome Improvement Target 2: Estimated Incentive Payment*:*** $113,655
Year 2 Estimated Outcome Amount: $43,763	**Year 3 Estimated Outcome Amount:** $55,035	**Year 4 Estimated Outcome Amount:** $65,914	**Year 5 Estimated Outcome Amount:** $113,655
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $278,366			

Outcome Measure Title: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure)
Performing Provider: Covenant Children's Hospital/127319504
Unique Outcome Identifier: 127319504.3.1
Outcome Domain: OD- 9 Right Care, Right Setting

Outcome Measure Description:

As a Children's hospital we identified reducing pediatric/young adult asthma emergency department visits as a high priority quality improvement initiative. Through the Covenant Children's Hospital Asthma Navigation Program we expect to reduce ED utilization of children with asthma by 10% from the baseline by the end of the waiver period. By providing a new patient and family centric paradigm to facilitate behavioral change among patients with asthma and their families, we will improve the health outcomes of low-income populations. Our estimate is that Medicaid and or low-income patients will be the 74% of those enrolled in the program. This program will serve as the bridge or liaison to a population of people who have problems navigating the health care system effectively and who also lack the resources to do so.

As noted in the table below, milestones establish our path to continue working with stakeholders, to establish our baseline rates, and then begin reporting on the improvements for targeted patients enrolled in the Covenant Children's Hospital Asthma Navigation Program. We will establish hard targets for Outcome Improvement 9.3 in DY 3.

The CDC 2011 National Health Survey states over 7 million children in the US under age 18 have asthma. Non-Hispanic black children are more likely to have asthma than Hispanic children or non-Hispanic white children. Children in poor families are more likely to have asthma than children in families that are not poor.

Prevalence of asthma among children (persons aged <18 years) was 9.6%, and was highest among poor children (13.5%) and among non-Hispanic black children (17.0%). The CDC estimates one in ten children have asthma. In Texas in 2009, the CDC estimated 8.2% or 538,000 children currently have asthma. The 2010 US Census Bureau reported the population of Lubbock County at 283,910 with 67,477 of the population being children less than 18. The 2010 US Census Bureau reports 19% of persons in Lubbock County are living below poverty level. Lubbock County is 31% Hispanic and 7.8% non-Hispanic black. Based off the CDC's estimation of one in ten children having asthma and the Texas prevalence of 8.2%, Lubbock County has 5,500 to 6,700 children with asthma.

Rationale:

We selected these process milestones and outcome measure because Covenant Children's Hospital currently has a relatively high rate of asthma revisits to the pediatric Emergency Department, 21%. As some visits are potentially preventable, we expect to reduce the potentially preventable ED visits for pediatric patients with chronic asthma. Many of the patients with asthma have exacerbations due to lack of knowledge regarding Asthma triggers, lack of established PCP, access to PCP, low health literacy for parents and medication adherence. An evidenced-based program such as the asthma navigator will work with patients and their parents to educate, change behaviors and ultimately reduce unnecessary or potentially preventable ED visits.

Outcome Measure Valuation:

Asthma consists of more than 40% of the claims from the Covenant Children's Hospital ED. Based on the high volume and occurrence of Asthma in the ED and in RHP 12, we look to improve quality of life, better coordinate care, and reduce costs associated with treatment in the ED. Medicaid patients and uninsured patients find it difficult to access care and thus utilize the ED as their primary health care stop. We can improve their prospective of the Healthcare infrastructure by educating and acting as liaisons between the patients and their providers. This in turn will further develop and maintain a more effective care delivery system. We have adopted the RHP 12 valuation tool which proportionately assigns value to these Category 3 outcomes based on the weights assigned to the Category 2 Patient Navigator project which is the catalyst for these expected outcome improvements. Additionally, this program will also positively impact the PPR 30 day rate for Asthma.

Childhood asthma has both direct costs and indirect costs associated with it. In terms of direct costs most Children's Hospitals base this on the total costs for caring for Children in the Emergency department (estimated at $600 per ED encounter) and the total costs for caring for children with asthma as an inpatient (estimated to be at $6600 per inpatient encounter). In Fiscal Year 2011 the total cost for caring for children with asthma at Covenant Children's was estimated to be $2,307,000. This has increased by 12% for FY 2012 to an estimated $2,587,200. Indirect costs include missed days from school and parents' loss of productivity. In a study by the CDC it has been estimated that on average there are 2.48 school absence days annually per child with asthma. In that same study, it is estimated that parents' loss of productivity costs on average $285 per child with asthma annually. Covenant Children's has approximately 750 children with asthma being treated annually. We would estimate that on average these children account for a combined school absence days per year of 1860 and a combined loss of parents' productivity costing approximately $213,750 per year. Through this project we will enroll 400 patients into a Patient Navigator program that will reduce both direct and indirect costs associated with childhood asthma.

127319504.3.1	3.IT-9.3	IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure)	
Covenant Children's Hospital			**127319504**
Related Category 1 or 2 Projects:	**127319504.2.1, Covenant Children's Hospital Asthma Navigation Program**		
Starting Point/Baseline:	**Covenant Health System has two pilot navigator projects which have reduced 30 day PPRs and Potentially Preventable ED visits (PPVs). We will establish a baseline for this target population.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of Planning Activities Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $292,606	**Process Milestone 2** P- 2 Establish baseline rates Data Source: EMR, Claims Process Milestone 2 Estimated Incentive Payment: $339,172	**Outcome Improvement Target 1** IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure) a Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. b Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. Data Source: EMR, Claims Improvement Target: TBD for DY 4. (Anticipate 10% reduction from estimated baseline of 200 by DY 4). Outcome Improvement Target 1 Estimated Incentive Payment*:* $544,249	**Outcome Improvement Target 2** IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure) a Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. b Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. Data Source: EMR, Claims Improvement Target: TBD for DY 5. (Anticipate 20% reduction from estimated baseline of 200 by DY 5). Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,301,463
Year 2 Estimated Outcome Amount: $292,606	Year 3 Estimated Outcome Amount: $339,172	Year 4 Estimated Outcome Amount: $544,249	Year 5 Estimated Outcome Amount: $1,301,463
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,477,490			

Outcome Measure Title: IT-4.8 Sepsis Mortality
Performing Provider: Covenant Medical Center/139461107
Unique Outcome ID: 139461107.3.1
Outcome Domain: OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

Outcome Measure Description:
Covenant Health System has a preliminary baseline Observed/Expected Mortality > 1 for sepsis patients. This is an area that can be targeted for improvement both in terms of outcomes and quality of care. The primary outcome for the management of sepsis is mortality. As noted in the Sepsis Quality Initiative in Category 2, Covenant has selected sepsis as a critical area to improve our performance and mortality as the most critical outcome for our patients to measure this performance against. We aim to improve our performance as reported in the Premier database to achieve an Observed/Expected Mortality for sepsis of <1 by DY 5. During DY4 the goal is to reduce Sepsis mortality by 15% to an O/E ratio of ~1.10. Based on an annualized 136 mortalities, this would be 20 less deaths per year in the Lubbock Region. The goal in DY5 is to reduce Sepsis mortalities by an additional 15%, to an Observed/Expected Ratio of 0.95.

As noted in the table below, milestones establish our path to continue working with stakeholders, to establish baseline rates which will be shared with staff to spur improvements, and then to ultimately achieve improvements, both absolute and relative, in mortality rates.

Rationale:
Covenant Health System selected process milestones to support the internal decisions and changes that must be incorporated and adopted to improve mortality outcomes for patients with sepsis. We selected the mortality improvement target in order to measure our performance against the most critical outcome for patients. Our DY 5 goal is to reduce the mortality ratio to less than 1. During DY4 the goal is to reduce Sepsis mortality by 15% to an O/E ratio of ~1.10. Based on an annualized 136 mortalities, this would be 20 less deaths per year in the Lubbock Region. The average age of our patients with Sepsis is 72 years (range 24-96). Using a conservative estimate of 8 additional years of life if these preventable deaths are avoided, would yield 160 patient years of life saved for this group. Using a standard Quality Adjusted Life Year value of $50,000 (a conservative value based on recent estimates in the United States), this would have an impact of $8,000,000 from the gains made in DY4.
The goal in DY5 is to reduce Sepsis mortalities by an additional 15%, to an Observed/Expected Ratio of 0.95. When a sustained mortality improvement from DY4 is applied to CH's annualized baseline, there would be a projected 99 mortalities from Sepsis in the Lubbock Region in DY5 without intervention. The target for DY5 is an additional 15% improvement, to reach an Observed/Expected

mortality ratio of 0.95. (The overall target for the initiative is an O/E mortality ratio of <1 by the end of DY5.) The additional improvement in mortality in DY5 leads to 15 avoidable deaths. Applying the same parameters used above to these 15 patients (8 years of additional life, 150 years of life saved, QALY of $50,000/year) yields an economic benefit of $6,000,000. The total impact of the program, prior to any additional savings from improved care and avoided complications in this population is $14,000,000 during DY4 and DY5. Sustainment of the O/E mortality ratio at 0.95 would provide an ongoing yearly benefit of at least $6,000,000 benefit from baseline. The 4 year ~$13.5 million cost of the program compared to the $14 million dollar impact in the final two years of the program yields a benefit to cost ratio of >1. The benefit to cost ratio increases in each subsequent year that the O/E mortality ratio is maintained at 0.95 or less.

In order to achieve the goals set forth, we will develop a protocol based on the Institute for Healthcare Improvement's Surviving sepsis campaign. This protocol will include the development of the protocol and a physician order set based on national standards of care. In addition, we will designate a Sepsis Coordinator to run the program and provide education to our staff. Physician Medical Directors will oversee the clinical aspects and be responsible for the outcomes. Physician Champions will promote the use of the protocol by engaging their colleagues and promoting these best practices. The clinical staff and physicians at all Covenant facilities will undergo initial education, with updates provided on a yearly basis. The project will include the designation of the sepsis coordinator, Medical Directors and Physician Champions. The number of clinical and physician staff undergoing education will be tracked and reported through Category 2 milestones and metrics.

Outcome Measure Valuation:

It is difficult to place a value on a life saved. Covenant Health System will monitor the cost per case to treat sepsis, and we have identified an internal targeted improvement of ~7.3% in this metric based on current cost and comparison to our peer group's cost to treat sepsis cases. Since this project is not designated as cost containment project, this metric will not be reported through Category 3. As noted in our Category 2 valuation, Covenant Medical Center is relied upon by our surrounding smaller and rural hospitals for tertiary care of patients with sepsis. Therefore, it is important for RHP 12 that our staff is trained in and provides evidence-based care for the treatment of severe sepsis and septic shock.

RHP 12 identified a weighting scale to value projects more uniformly across our region. In using that tool, a Category 3 proportional valuation amount has been allocated for Sepsis Category 3 outcomes. As noted in the Category 2 project related to the Sepsis Quality Initiative, Covenant Hospitals Levelland and Plainview collaborated with Covenant Medical Center to do a more robust project across the three different Covenant adult hospitals. Covenant Women's Children's Hospital will also be included in the System quality improvement initiative for adults and children.

139461107.3.1	3.IT-4.8	IT-4.8 Sepsis mortality	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects::	**139461107.2.1**		
Starting Point/Baseline:	**Preliminary baseline is Observed/Expected Mortality > 1.**		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan **Data Source:** Planning Documentation **Process Milestone 1 Estimated Incentive Payment:** $257,972	**Process Milestone 2** P- 2 Establish baseline rates **Data Source:** Premier database **Process Milestone 2 Estimated Incentive Payment:** $299,024	**Outcome Improvement Target 1** IT-4.8 Sepsis mortality (Standalone measure) a. Numerator: Number of patients expiring during current month hospitalization with severe sepsis or septic shock and/or an infection and organ dysfunction. b. Denominator: Number of patients identified that month with severe sepsis or septic shock and/or an infection and organ dysfunction. **Data Source:** Premier Database **Improvement Target:** Observed/Expected Mortality <1 15% to an O/E ratio of ~1.10. Based on an annualized 136 mortalities, this would be 20 less deaths per year in the Lubbock Region. We will review again once methodology for Category 3 Outcomes is finalized. **Outcome Improvement Target 1 Estimated Incentive Payment:** $479,831	**Outcome Improvement Target 2** IT-4.8 Sepsis mortality (Standalone measure) a. Numerator: Number of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction. b. Denominator: Number of patients identified that month with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction. **Data Source:** Premier Database **Improvement Target:** Observed/Expected Mortality <1 Additional 15% improvement, to reach an Observed/Expected mortality ratio of 0.95. We will review again once methodology for Category 3 Outcomes is finalized. **Outcome Improvement Target 2 Estimated Incentive Payment:** $1,147,411
Year 2 Estimated Outcome Amount: $257,972	Year 3 Estimated Outcome Amount: $299,024	Year 4 Estimated Outcome Amount: $479,831	Year 5 Estimated Outcome Amount: $1,147,411
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,184,238			

Outcome Measure Title: IT-3.12 Other: Diabetes Risk-Adjusted 30 Day Readmission Rate (Standalone measure)
Performing Provider: Covenant Medical Center/ 139461107
Unique Outcome ID: 139461107.3.2
Outcome Domain: OD-3 Potentially Preventable Re-Admissions

Outcome Measure Description:
Many of the patients with chronic diseases such as Diabetes, Hypertension, COPD, CHF and CAD with a co-morbidity of obesity have exacerbations due to lack of knowledge regarding their condition, lack of established PCPs, access to PCPs, low health literacy and low medication adherence. An evidenced-based program such as the Covenant Hospital Adult Navigator Program will work with high-risk patients to educate, to change behaviors and to ultimately reduce potentially preventable ED and readmission visits. We have selected IT-3.12 as an "other" PPR rate as in accordance with CMS and HHSC protocols, we seek to use risk adjusted PPR rates for diabetes.
As noted in the table below, our milestones will monitor our progress as we will work with stakeholders to plan for this pay for outcome project, establish our baseline rates, test the system, and then begin reporting on the improvements for Diabetes Risk Adjusted PPR rates for targeted patients enrolled in the Covenant Hospital Adult Navigator Program. Outcome improvement targets for DY 4 and DY 5 will be determined in DY 2 or 3.

Rationale:
The goal of the Covenant Hospital Adult Navigator Program is to improve health outcomes for persons enrolled in the program. Adults with chronic conditions such as diabetes, heart disease and obesity, particularly those who are minority or middle to lower socio-economic status, often encounter significant practice and health system barriers to accessing quality care. The program will provide individualized, cost-effective ways to reduce obstacles to care by providing social and medical support. Navigators will provide educational support to patients through education about disease management, facilitate medication adherence, identify and facilitate resource procurement and improve communication between providers. By removing barriers to ongoing and preventive quality care, like blood pressure checks, we expect to improve health outcomes for patients enrolled in the Navigator program. In order to measure improvements, we selected milestones to establish the baseline health for patients. Once the baseline health is established for these patients, improvement targets to reduce PPRs for this target population will be set for DY 4 and DY 5. PPRs were selected as it will account for the individualized care experience as well as measure the system as a whole. There will be cost avoidance for public payers as well as improved maneuvering through the ever expanding continuum of care for adults as well as improved patient outcomes. Through the Covenant Hospital Adult Navigator Program we expect to enroll over 800 patients by DY 5. Needs assessment data indicates that the prevalence of overweight and obesity among RHP residents is as high as

65.8% for men and 58.5% for women. 10.7% of individuals that reside just in Lubbock County alone have diabetes, 7.8% have Coronary Artery Disease and account for 24% of Medicaid admissions for Covenant. 11.6% have COPD with a higher incidence among Hispanics. Baseline for 30 day readmission was 259 for 2011 for Diabetes, Index 30 day readmissions was 103. Improvement target will be 45% in DY4 and 60% in DY5.

Outcome Measure Valuation:

RHP 12 identified a weighting scale to value projects more uniformly across our region. In using that tool, a Category 3 proportional valuation amount has been allocated for the Covenant Hospital Adult Navigator Program Category 3 outcomes. This is supported by the following cost containment strategies and improved quality of care components of the project.

Cost of care for patients with the targeted chronic conditions was approximately $14.6 million in 2011 at Covenant Medical Center. Covenant Health is committed to this local investment and program expansion to reduce the burden on more acute care services, like inpatient and ED visits. Additionally Covenant has demonstrated through the pilots that providing assistance to patients and to their families to better and more efficiently maneuver the various service sites improves patient outcomes and reduces the cost burden on the total system.

Evidence exists that this type of program is effective through pilot studies tested locally. Two pilot projects have been conducted in the outpatient and inpatient setting. The outpatient setting project documented in the Online Journal of Issues in Nursing proved to be successful in decreasing ED visits and hospitalization for patients with Asthma as well as biometric and behavioral changes for patients with Hypertension and Diabetes (Esperat, M. C.; Flores, D.; McMurry, L.; Feng, D.; Song, H.; Billings, L.; Masten, Y. [May 31, 2012] "Transformacion Para Salud: A Patient Navigation Model for Chronic Disease Self-Management" OJIN: the Online Journal of Issues in Nursing Vol. 17, No. 2, Manuscript 2.). The goal of the second pilot project with two local hospitals was to prevent 30 day readmissions and ED visits for patients without Primary Care providers who were admitted with Hypertension, Diabetes, CHF, COPD or Asthma. This project, which is still in the pilot stage, has proven successful thus far with approximately 30 patients enrolled and only 1 readmission and 1 ED visit. As our health care system transforms into a more patient centered and value based purchasing system, we must focus on increasing patients' ability to self-manage and make cost effective care choices. Average cost for admission for a chronic condition ranges from $2,000 to $6,000 (according to internal data source, AMALGA) so there is a potential savings in readmission as well as behavior changes that would delay the onset of complications.

The Covenant Adult Navigator program will enroll over 800 Medicaid and Uninsured patients by year 5. Improvement Targets are To Be Determined (TBD) as a baseline must be established.

139461107.3.2	**3.IT-3.12**	IT-3.12 Diabetes Risk-Adjusted 30 Day Readmission Rate	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects:	**139461107.2.2, Covenant Hospital Adult Navigation Program**		
Starting Point/Baseline:	**Covenant Health System has two pilot navigator projects which have reduced 30 day PPRs and Potentially Preventable ED visits (PPVs). We will establish a baseline for this target population.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans <u>Metric 1</u> P-1.1 Metric: Project planning complete a. Documentation of planning and process using a timeline Baseline/goals: Timeline will begin October 2012 and show program implementation by 09/30/2013. Data Source: Documentation of Plan, timelines, etc. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $119,772	**Process Milestone 3** P-3 Develop and test data systems <u>Metric 1</u> P-3.1 Metric-Development and testing of data systems a. Data base will be tested for accurate and robust reporting Baseline/goals: Database will be tested to include collection of clinical as well as behavioral outcomes and will be ready for use on 11/01/2013. Data Source: Data system Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $277,663	**Outcome Improvement Target 1** IT-3.12 Diabetes Risk Adjusted 30 Day Readmission rate a. Numerator: The number of clinically-related readmissions (for patients 18 years and older), within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. b. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. Improvement Target: Baseline for 30 day readmission was 259 for 2011, Index 30 day readmissions was 103. Improvement target will be 45% in	**Outcome Improvement Target 2** IT-3.12 Diabetes Risk Adjusted 30 Day Readmission rate c. Numerator: The number of clinically-related readmissions (for patients 18 years and older), within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. d. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. Improvement Target: 60% in DY 5 Data Source: Risk Adjusted PPR Report

139461107.3.2	**3.IT-3.12**	IT-3.12 Diabetes Risk-Adjusted 30 Day Readmission Rate	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects:	**139461107.2.2, Covenant Hospital Adult Navigation Program**		
Starting Point/Baseline:	**Covenant Health System has two pilot navigator projects which have reduced 30 day PPRs and Potentially Preventable ED visits (PPVs). We will establish a baseline for this target population.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 2: P-2 Establish baseline rates <u>Metric 1</u> P-2.1 Baseline rates will be established Baseline/goal: Establishment of baseline with 6 to 12 months of continuous data will be complete by 09/30/2013. Data Source: EMR, Claims Process Milestone 2 Estimated Incentive Payment: $119,772		DY4 Data Source: Risk Adjusted PPR Report Estimated Incentive Payment*:* $445,553	Estimated Incentive Payment*:* $1,065,452
Year 2 Estimated Outcome Amount: $239,544	Year 3 Estimated Outcome Amount: $277,663	Year 4 Estimated Outcome Amount: $445,553	Year 5 Estimated Outcome Amount: $1,065,452
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $2,028,212			

Outcome Measure Title: IT-10.1 Quality of Life
Performing Provider: Covenant Medical Center/ 139461107
Unique Outcome ID: 139461107.3.3
Outcome Domain: OD-10.1 Quality of Life/Functional Status

Outcome Measure Description:

This project will work with stakeholders and establish baselines and improvement measures in the quality of life through the implementation of the Covenant Transitional Outpatient Psychiatric Clinic, which will facilitate appropriate transition processes that are now fragmented and develop effective mechanism to accomplish this effectively. This will be measured by utilizing a pre-discharge quality of life assessment and a post discharge assessment. As noted in the table below, our milestones will monitor our progress as we will work with stakeholders to plan for this pay for outcome project, establish our baseline rates, test the system, and then begin reporting on the improvements for Quality of Life for targeted patients enrolled in Program. Outcome improvement targets for DY 4 and DY 5 will be determined in DY 2 or 3.

Rationale:

Average ED charges for ED utilization for patients (approximate 1386 per year) with a behavioral health primary diagnosis is $3,148. There were a total of 1,129 ED visits in 2012. The expense and hardship caused by repeated ED visits and readmissions coupled with the lack of community resources would drive the improvement of Quality of Life scores through the implementation of the Transitional Care Program. The Covenant Needs Assessment conducted in 2011 indicated a gap in medical interventions, prescription assistance and prescription management for uninsured and Medicaid mental health patients. In addition to these gaps the same needs assessment indicated that other MHMR services were not accepting new patients which leads to an increase in ED visits and hospitalizations. The multiple services offered by the Transitional Outpatient Clinic would fill some of these gaps and improve the Quality of Life for this population to 20% in DY4 and 40% by DY5. The Category 2 project, Covenant Transitional Outpatient Psychiatric Clinic seeks to improve transition processes that are now fragmented and develop effective mechanism to accomplish this effectively. By incorporating evidenced-based elements from projects such as WRAP, CTI and SAMHSA endorsed project interventions; this project will demonstrate improvement in quality of life. The underserved populations of our region are the most vulnerable to the gaps in services. Their lack of resources, some as simple as transportation, make it difficult for them to navigate through the mental health care arena. This project will focus on serving that population, beginning with discharge from the psychiatric unit when they are the most vulnerable to relapse. Providing outreach services post-discharge of the unit and post-visit to the ED will improve the patient's quality of life, which is why this measure was selected. This will be assessed using a validated instrument prior to discharge and at appropriate intervals.

This project follows evidenced based protocols which have documented improvement in access to care, decreased ED utilization, increased medication adherence and thus improved overall quality of life.

Outcome Measure Valuation:

RHP 12 identified a weighting scale to value projects more uniformly across our region. In using that tool, a Category 3 proportional valuation amount has been allocated for the Covenant Transitional Outpatient Psychiatric Clinic Category 3 outcomes for Quality of Life. This is supported by the cost containment strategies and improved quality of care components of the project. Using this tool and guidelines, the valuation considers that the Covenant Transitional Outpatient Psychiatric Clinic's aim to improve quality of life and functional status for patients who are receiving the transitional care coordination. The patients will continue to receive high quality, patient centered care post inpatient admission and beyond their ED visits. The outpatient services provided will improve the healthcare infrastructure by expanding access and capacity for needed behavioral healthcare in the community where the Medicaid and uninsured patients reside. Patient centered care and team coordination will focus on engaging the patient in his/her own treatment direction which will improve symptom management, functionality and health outcomes over the life of the patient. We expect that improving medication management will improve a patient's community role and function with regarding to their ability to find a job and/or return to work. By coordinating transportation needs, patients will be able to participate in on-going treatment and increased functionality. We are committed to the focus on improvement of patient outcomes for this Medicaid and uninsured target population.

139461107.3.3	3.IT-10.1	IT-10.1 Quality of Life	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects:	**139461107.2.3, Covenant Transitional Outpatient Psychiatric Clinic**		
Starting Point/Baseline:	**This is a new program. Baseline will be established for these patients in DY 3.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of Plans and Stakeholder Engagement. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $294,824	**Process Milestone 2** P-2 Establish baseline rates Data Source: EMR and Survey of Quality of Life results from Pre and Post Discharge Process Milestone 2 Estimated Incentive Payment: $341,739	**Outcome Improvement Target 1** IT-10.1 Quality of Life-275,276,277 (Standalone measure) a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Data source: Provider may select a validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL Improvement Target: 20% improvement in QOL scores from baseline. Outcome Improvement Target 1 Estimated Incentive Payment*:* $548,372	**Outcome Improvement Target 2** IT-10.1 Quality of Life-275,276,277 (Standalone measure) a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Data source: Provider may select a validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL Improvement Target: 40% improvement in QOL scores from baseline Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,311,326
Year 2 Estimated Outcome Amount: $294,824	Year 3 Estimated Outcome Amount: $341,739	Year 4 Estimated Outcome Amount: $548,372	Year 5 Estimated Outcome Amount: $1,311,326
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,496,261			

Outcome Measure Title: IT-13.1 Pain Assessment (NQF_1637)
Performing Provider: Covenant Medical Center/139461107
Unique Outcome ID: 139461107.3.4
Outcome Domain: OD-13 Palliative Care

Outcome Measure Description:

Currently and traditionally pain assessments only take place in the inpatient setting. Therefore, upon discharge patients may not understand nor have the ability to manage their pain effectively. Through the implementation of the Covenant Outpatient Palliative Clinic, an ESAF assessment tool will be implemented and administered each time the patient visits the clinic. An appropriate treatment plan to meet their goals of care will be implemented within 24 hours of initiation of plan of care. As noted in the table below, our milestones will monitor our progress as we will work with stakeholders to plan for this pay for outcome project, establish our baseline rates, and then begin reporting on the improvements for targeted patients. Outcome improvement targets for DY 4 and DY 5 will be determined in DY 2 or 3.

Rationale:

The IT-13.1 Pain Assessment measure was selected to emphasize the need for pain assessment in palliative care which can reduce the burden on emergency room providers when a pain crisis occurs for patients who do not have any other readily available access to care. Pain is under-recognized by clinicians and often treated ineffectively. Appropriate pain assessment management provided by the Covenant Outpatient Palliative Clinic will enhance the quality of life for patients with life-limiting illnesses. Improvement targets will be determined in DY3.

Outcome Measure Valuation:

RHP 12 identified a weighting scale to value projects more uniformly across our region. In using that tool, a Category 3 proportional valuation amount has been allocated for the Covenant Outpatient Palliative Clinic Category 3 outcomes. There are three non-standalone outcomes which increases the aggregate amount dedicated to these related Category 3 outcomes. This is supported by regional goals to increase access to palliative care counseling, increase services and projects to expand patient centered healthcare models and pursue cost containment strategies while improving quality of care for patients. Although it is difficult to value pain control, the number of patients who currently use the ED for chronic disease pain management will serve as the baseline for measurement. A robust database will be established to capture pre and post visit assessment scores. Total number of patients who receive pain management assessment and plan of care within 24 hours of care initiation divided by the total number of patients seen in the palliative care program will provide outcome data and interventions will be adjusted accordingly. Data

sources are the EHR and claims. Palliative care is one model of patient centered care which is the backbone of transformation for our health care system. We seek to better enable patients to direct their own care.

139461107.3.4	3. IT-13.1	IT-13.1 Pain Assessment (NQF_1637)	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects:	**139461107.2.4, Covenant Outpatient Palliative Clinic**		
Starting Point/Baseline:	**Covenant Health System will establish a baseline for the patients served through the Clinic.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of Planning Process, Timeline and Plan **Process Milestone 1 Estimated Incentive Payment*:*** $221,118.00	**Process Milestone 2** P-2 Establish baseline rates **Data Source:** Report Baseline Rates to State **Process Milestone 2 Estimated Incentive Payment:** $256,305.00	**Outcome Improvement Target 1** IT-13.1 Pain Assessment Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. **Improvement Target:** TBD Per HHSC Guidance, Category 3 methodology is under construction. We estimate a goal of 90% compliance rate of patients 135/150 participating in the program per year . **Data Source:** EMR/Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $411,279	**Outcome Improvement Target 2** IT-13.1 Pain Assessment Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. **Improvement Target: TBD** Per HHSC Guidance, Category 3 methodology is under construction. We estimate a goal of 95% of compliance rate of patients 143/150 participating in the program per year. **Data Source:** EMR/Claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $983,494
Year 2 Estimated Outcome Amount: $221,118	**Year 3 Estimated Outcome Amount:** $256,305	**Year 4 Estimated Outcome Amount:** $411,279	**Year 5 Estimated Outcome Amount:** $983,494
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,872,196			

Outcome Measure Title: IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss.
Performing Provider: Covenant Medical Center/139461107
Unique Outcome ID: 139461107.3.5
Outcome Domain: OD- 13 Palliative Care

Outcome Measure Description:

The Covenant Outpatient Palliative Clinic expects to expand access to palliative care counseling and consult including the option to discuss spiritual concerns. Presenting the option to the patient increases the patient-centered plan model. We have identified IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss (NQF 1647 modified) as one of the outcome improvements we expect for the patient. As noted in the table below, our milestones will monitor our progress as we will work with stakeholders to plan for this pay for outcome project, establish our baseline rates, and then begin reporting on the improvements for targeted patients. Outcome improvement targets for DY 4 and DY 5 will be determined in DY 2 or 3.

Rationale:

Patients and families, who are facing life-limiting and/or chronic illnesses often, have complex psycho-social issues that must be addressed. As their illness becomes more complex, the stress of these issues often creates diminished quality of life for the patient and the family. Researches have noted the importance of identifying and addressing a patient's spiritual needs as part of the holistic approach to health care, especially the model presented by palliative medicine. By performing and documenting a patient's spiritual beliefs and providing resources to address those concerns, quality of life has been demonstrated to improve. Because of this improvement, we believe it is important to offer patients the opportunity to have these conversations.

Additionally, studies have shown that pain is produced in many forms and from numerous causes. Pain is a complex subjective experience that involves both neurophysiologic and emotional aspects. Many individual factors can affect a person's experience of pain and subsequent response to treatment include their past experiences with pain, the meaning they assign to their current pain and underlying mood disorders (anxiety, depression, anger). At times cognitive dimensions of pain along with psychosocial and spiritual issues can produce an overwhelming amount of suffering mentally and emotionally. (See Paice JA. Managing psychological conditions in palliative care. AJN 2002;102(11):36-43)

The Covenant Outpatient Palliative Clinic will assess spiritual needs and concerns for each patient. Patients who have needs and concerns will be referred to a Covenant Health chaplain or to a spiritual advisor of their choice. Additionally, the outpatient palliative medicine clinic will work with the bereavement department of Hospice of Lubbock and the Covenant Health Counseling Center to ensure patients have access licensed professional counselors who can help deal with the effects of spiritual and emotional stress. The team will utilize the information gathered to address not only the physical elements of pain and like symptoms, but also address the psycho-social and spiritual components.

Outcome Measure Valuation:

RHP 12 identified a weighting scale to value projects more uniformly across our region. In using that tool, a Category 3 proportional valuation amount has been allocated for the Covenant Outpatient Palliative Clinic Category 3 outcomes. There are three non-standalone outcomes which increases the aggregate amount dedicated to these related Category 3 outcomes. This is supported by regional goals to increase access to palliative care counseling, increase services and projects to expand patient centered healthcare models and pursue cost containment strategies while improving quality of care for patients. The impact of spiritual and religious counseling at end of life or while battling ongoing painful conditions is difficult. However, we have identified that patients experiencing physical pain can have exacerbated emotional distress and grave potential for discouragement. Through the Covenant Outpatient Palliative Clinic, we will offer spiritual counseling and specific religious referrals as part of the palliative care services. We will establish a database to track the offering and acceptance of spiritual care counseling and expect to see increases for this service. Palliative care is one model of patient centered care which is the backbone of transformation for our health care system. We seek to better enable patients to direct their own care.

139461107.3.5	3. IT-13.5	Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss.	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects:	139461107.2.4, Covenant Outpatient Palliative Clinic		
Starting Point/Baseline:	Covenant Health System will establish a baseline for the patients served through the Clinic.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of Planning Process, Timeline and Plan **Process Milestone 1 Estimated Incentive Payment**: $221,118	**Process Milestone 2** P-2 Establish baseline rates **Data Source:** Report Baseline Rates to State **Process Milestone 2 Estimated Incentive Payment:** $256,305	**Outcome Improvement Target 1** IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure) **Data Source:** EHR, Claims **Improvement Target:** TBD Per HHSC Guidance, Category 3 methodology is under construction. We estimate a goal of 90% compliance rate of patients participating in the program per year . **Outcome Improvement Target 1 Estimated Incentive Payment:** $411,279	**Outcome Improvement Target 2** IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure) **Data Source:** EHR, Claims **Improvement Target:** TBD Per HHSC Guidance, Category 3 methodology is under construction. We estimate a goal of 90% compliance rate of patients participating in the program per year . **Outcome Improvement Target 2 Estimated Incentive Payment:** $983,494
Year 2 Estimated Outcome Amount: $221,118	**Year 3 Estimated Outcome Amount**: $256,305	**Year 4 Estimated Outcome Amount**: $411,279	**Year 5 Estimated Outcome Amount:** $983,494
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,872,196			

Outcome Measure Title: IT-13.2 Treatment Preferences (NQF 1641)
Performing Provider: Covenant Medical Center/139461107
Unique Outcome ID: 139461107.3.6
Outcome Domain: OD- 13 Palliative Care

Outcome Measure Description:

Patients with chronic conditions typically do not understand their treatment options, and often the cost of life-sustaining treatments may leave their families with an enormous financial burden that may not have happened if the patient and family received appropriate education about their choices for quality care. Not only does this lack of information and patient centered care drive cost for the hospital units, but it may affect the quality of life for the patient. All patients participating in the Covenant Outpatient Palliative Clinic will have their treatment preferences for life sustaining treatments documented. Documentation will show education on treatments and the opportunity for patients to fully complete advance directives. We plan to target 100% of patients who receive care through the outpatient palliative program. If the patient and their family are not ready to make such choices, education and guidance will be provided by the caseworkers until they are ready. As noted in the table below, our milestones will monitor our progress as we will work with stakeholders to plan for this pay for outcome project, establish our baseline rates, and then begin reporting on the improvements for targeted patients. Outcome improvement targets for DY 4 and DY 5 will be determined in DY 2 or 3.

Rationale:

Patients with Chronic conditions tend to not understand their treatment options and the cost of life-sustaining treatments may leave their families with an enormous financial burden that may not have happened if the patient and family received appropriate education about their choices. Not only does this drive cost for the hospital units but it may affect the quality of life for the patient. Often times a patient's treatment preferences regarding life sustaining treatments are not documented nor do the patient and/or family understand the treatment preferences and their relation to the individual's overall quality of life. Undocumented treatment preferences often lead to decreased patient rights, lack of dignity and family strife and stress, along with unneeded or unwanted resource allocations. Because these discussions improve patient understanding and engagement, these choices will be discussed with the patient and his/her family at each visit. A patient database will contain the progress made in obtaining this documentation.

Outcome Measure Valuation:

RHP 12 identified a weighting scale to value projects more uniformly across our region. In using that tool, a Category 3 proportional valuation amount has been allocated for the Covenant Outpatient Palliative Clinic Category 3 outcomes. There are three non-standalone outcomes which increases the aggregate amount dedicated to these related Category 3 outcomes. This is supported by regional goals to increase access to palliative care counseling, increase services and projects to expand patient centered healthcare models and pursue cost containment strategies while improving quality of care for patients. As the total number of patients who have their life sustaining treatment options discussed and documented increases, the total number who is admitted to inpatient units for costly treatments not chosen by the patient will decrease. We believe that communication improves when patients are offered appropriate treatment options. Palliative care is one model of patient centered care which is the backbone of transformation for our health care system. We seek to better enable patients to direct their own care.

139461107.3.6	3.IT-13.2	IT-13.2 Treatment Preferences (NQF 1641)	
Covenant Medical Center			139461107
Related Category 1 or 2 Projects:	**139461107.2.4, Covenant Outpatient Palliative Clinic**		
Starting Point/Baseline:	**Covenant Health System will establish a baseline for the patients served through the Clinic.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of Planning Process, Timeline and Plan Process Milestone 1 Estimated Incentive Payment: $221,118	**Process Milestone 2** P-2 Establish baseline Data Source: Report Baseline Rates to State Process Milestone 2 Estimated Incentive Payment: $256,305	**Outcome Improvement Target 1** IT-13.2 Treatment Preferences (NQF 1641) Percentage of patients with chart documentation of preferences for life sustaining treatments Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice. Data Source: EHR, Claims Improvement Target: TBD Per HHSC Guidance, Category 3 methodology is under construction. We estimate a goal of 90% compliance rate of patients participating in the program per year . Outcome Improvement Target 1 Estimated Incentive Payment: $411,279	**Outcome Improvement Target 2** IT-13.2 Treatment Preferences (NQF 1641) Percentage of patients with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice. Data Source: EHR, Claims Improvement Target: TBD Per HHSC Guidance, Category 3 methodology is under construction. We estimate a goal of 95% compliance rate of patients participating in the program per year . Outcome Improvement Target 2 Estimated Incentive Payment: $983,494
Year 2 Estimated Outcome Amount: $221,118	Year 3 Estimated Outcome Amount: $256,305	Year 4 Estimated Outcome Amount: $411,279	Year 5 Estimated Outcome Amount: $983,494
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,872,196			

Outcome Measure Title: IT-10.1 Quality of Life
Performing Provider: GOLDEN PLAINS COMMUNITY HOSPITAL/197063401
Unique Outcome ID: 197063401.3.1
Outcome Domain: OD-10 Quality of Life/Functional Status

Outcome Measure Description:
Through creating a COPD disease management registry, GPCH intends to increase the quality of life for Hutchinson County patients suffering from this chronic disease. GPCH will have increased contact with COPD patients, which will enable the hospital to monitor their health status and intervene earlier when treatment is indicated. This will prevent unnecessary hospitalizations, and lead to improved overall health outcomes for these patients. Further, the registry will enable GPCH to offer support, education, advice, and care coordination for Hutchinson County COPD patients, thereby reducing their stress and cost of accessing care. Ultimately, the registry is expected to produce an improvement in the quality of life scores for local COPD patients through providing a higher level of care, as measured by a validated assessment tool.

Project goal: The ultimate goals of this project are to identify a valid assessment tool for measuring quality of life in DY2, to establish a baseline showing current QoL scores for COPD patients in DY3, to improve the quality of life for COPD patients in the registry by 5% in DY4 (over the baseline), and by a total of 10% in DY5 (over baseline).

Milestones and Metrics:
Process: P1 – Project planning (DY2), P2- Establish a baseline (DY3)
Improvement: IT 10.1, 5% increase (DY4), IT 10.1, 10% increase (DY5)

Outcome Rationale:
Chronic disease takes a toll on the quality of life for all affected patients. The time it takes to manage the condition, plus the mental stress, additional cost, and complications that often ensure each lead to lower quality of life scores for those suffering from chronic conditions as compared to those in good health. This low quality of life merely exacerbates the effects of the condition on the patient. Thus, it is important to determine ways to improve the quality of life for these patients. The COPD registry is aimed at reducing the time, effort, and frustration associated with managing this disease; in turn, patient quality of life scores are expected to rise. The results of these surveys will enable GPCH to know if and how well its registry is functioning.

GPCH chose the DY2-3 process measures in order to identify a valid assessment tool, which is imperative for accurately measuring the patients' perspectives, and to establish a baseline upon which to base improvement. GPCH chose a 5% increase in QoL for both DY 4 and DY 5 because those numbers constitute a significant impact but are not unattainable.

***Related Category 1 and/or 2 project*:** 1.3.1 (Implement a Disease Registry

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	**Using a scoring system of 1-5, GPCH valued this project as follows:** The registry is meant to allow for better outreach and care coordination, and GPCH seeks an improvement in quality of life scores because it is in the best interest of the targeted patients. COPD is a prevalent problem in Hutchinson County, especially among seniors, who are more likely to be on Medicaid or uninsured. This outcome seeks to improve quality of life through coordinating and monitoring the care for COPD patients. Managing this condition will prevent it from becoming acute or worsening at a quicker pace than it otherwise would, which will reduce the overall costs of treating the condition.	**3**
Addresses Community Needs	This project addresses the following Region 12 Community Needs: CN.5 (Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung lung disease. Travel to Urban areas for care is difficult) and CN.10 (High prevalence of asthma and care issues). The registry will allow GPCH and its clinical staff to provide management and treatment locally to patients suffering from lung disease.	**2**
Project Scope/Size	Identifying all COPD sufferers in the County Increasing the number of visits for these patients, in order to improve their health and quality of life Training providers to use the registry Addressing respiratory illnesses/conditions, which are more prevalent in this county than many other counties in Texas, with industrial and environmental conditions being more severe than many counties	**2**
Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? This outcome will require: Human resources Equipment purchase and maintenance – the assessment tool Time to implement – 1 year to identify and train, 1 year to establish baseline, 2 years to improve Total value of this outcome/total value of category 3 projects: 10/61	**3**

197063401.3.1	*3.IT-10.1*	QUALITY OF LIFE	
GPCH LLC Golden Plains Community Hospital			**197063401**
Related Category 1 or 2 Projects(s):	**197063401.1.1**		
Starting Point/Baseline:	**GPCH will establish a baseline of quality of life scores for Hutchinson County patients with COPD in DY3, which GPCH will use to measure progress going forward**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Project planning: Identify a valid, evidence-based instrument by which to measure patient quality of life. Can include AQoL, SF-36, 20 or 12, PedsQL, etc. Train staff on administering the assessment tool. GPCH intends to use the Missoula-VITAS Quality of Life Index (MVQOLI) survey to assist in this analysis. **Data Source:** Documentation of training materials and the assessment tool identified. **Milestone 1 Estimated Incentive Payment*: $ 46,055***	**Milestone 2: P-2** Establish a baseline by identifying the present quality of life scores for patients in Hutchinson County suffering from COPD (using the assessment tool). **Data Source:** Aggregated assessment tool results. **Milestone 2 Estimated Incentive Payment:** $ $64,560	**Outcome Improvement Target 2** **IT 10.1** **Improvement Target:** Demonstrate 5% improvement in quality of life scores over baseline, as measured by an evidence-based and validated assessment tool for COPD patients in Hutchinson County entered into the registry. Metric: Numerator: Aggregated quality of life scores of COPD patients in the registry at GPCH for DY4,minus the DY3 Baseline Denominator: Aggregated quality of life scores of COPD patients in the registry at GPCH from DY3 baseline **Data Source:** Aggregated assessment tool results **Outcome Improvement Target 2 Estimated Incentive Payment:** $ $123,039	**Outcome Improvement Target 3** **IT 10.1** **Improvement Target:** Demonstrate 10% improvement in quality of life scores, as measured by an evidence-based and validated assessment tool for COPD patients in Hutchinson County entered into the registry. Metric: Numerator: Aggregated quality of life scores of COPD patients in the registry at GPCH for DY5, minus the DY3 baseline Denominator: Aggregated quality of life scores of COPD patients in the registry at GPCH from DY3 baseline **Data Source:** Aggregated assessment tool results **Outcome Improvement Target 3 Estimated Incentive Payment:** $329,505
Year 2 Estimated Milestone Bundle Amount: $ 46,055	Year 3 Estimated Milestone Bundle Amount: $ 64,560	Year 4 Estimated Milestone Bundle Amount: $ 123,039	Year 5 Estimated Milestone Bundle Amount: $ 329,505
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $563,159			

Outcome Measure Title: IT-1.7 Controlling High Blood Pressure
Performing Provider: GOLDEN PLAINS COMMUNITY HOSPITAL/197063401
Unique Outcome ID: 197063401.3.2
Outcome Domain: OD 1: Primary Care and Chronic Disease Management

Outcome Measure Description:
IMs are doctors who treat adult diseases, including hypertension and cardiac disease. Through the addition of an IM to the local primary care clinic, GPCH expects an increase in the control of high blood pressure for the community residents accessing the IM, and a corresponding reduction in the number of blood pressure related PPAs, PPRs, and patients requiring acute care. The increased control may come from early detection, medication management, and lifestyle suggestions, all provided by the IM.

Project goal: GPCH's goal is to achieve an 8% greater rate of GPCH hospital and clinic patients suffering from hypertension to maintain controlled blood pressure levels by DY5. This outcome will lead to better quality of life for patients (as they will be living healthier) and work to prevent the serious consequences of uncontrolled blood pressure, both in a quality of life sense and a cost sense.

Milestones and Metrics: The process milestones in DYs 2-3 will include establishing a baseline of the current rate of uncontrolled blood pressure in GPCH clinic patients, and project planning to engage stakeholders (the new IM, clinic staff, and patients) and identify a strategy for achieving the outcome. DYs 4-5 are will each reflect a 4% improvement over baseline each year, for a total 8% improvement in the number of hypertensive patients with controlled blood pressure.

Outcome Rationale:
The Region 12 Community Needs Assessment reports that there were 925 deaths from heart disease (which is often caused by high blood pressure) in the rural area of Region 12 in 2004, which represents about 3% of that population. In the same year, a total of 40,091 Texas residents were reported as dying from heart disease, which represents .02% of the Statewide population. Additionally, 56% of patients polled in Rural Region 12 reported high blood pressure being prevalent in their household. Clearly, heart disease and high blood pressure are serious problems in rural Region 12, justifying projects seeking to control this condition.

The process milestones were selected in order to allow GPCH time to put an effective strategy in place to achieve this essential improvement and to establish a baseline by which to measure improvement. The 4% improvement per year in DYs 4-5 should result in a decent number of patients gaining control of their conditions, and only reflects a floor (not a ceiling) amount.

Related Category 1 or 2 projects: 1.1.2 Expand Primary Care Capacity (Internal Medicine)

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	**Using a scoring system of 1-5, GPCH valued this project as follows:** This outcome is expected to result from an increased level and amount of high quality care and intervention into the management of patients' chronic diseases. Medicaid and uninsured Hutchinson County residents are the target population of the GPCH clinic, thus this initiative is expected be to their benefit. Finally, preventing the acute episodes and chronic diseases that can flow from uncontrolled high blood pressure will reduce costs and improve patient outcomes by extending and improving their lives.	**5**
Addresses Community Needs	This project addresses the following Region 12 Community Needs: CN.1 (Severe primary care provider shortage, wait time, expense, lack of insurance, access to care); CN.5 (Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung lung disease, partly because travel to Urban areas for care is difficult); and CN.10 (High prevalence of asthma and care issues). The addition of the IM will allow for better management of hypertension in the Borger and Hutchinson County community.	**4**
Project Scope/Size	Outreach to the targeted population to inform community members that the IM is available, and encourage them to come in and visit regularly Controlling patients' blood pressure will take regular contact with the identified patients, resulting in increased volume at the clinic The training and recruitment of 1 Internal Medicine Physician The savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations are expected to be meaningful. One of the most expensive long-term medical costs is ongoing dialysis for patients whose kidneys have failed due to high blood pressure. Currently, there are an estimated 15 people from our county receiving dialysis. With an estimated cost of $250,000 per patient for five years of dialysis, even two fewer patients on this service over life of the project will save $500,000 direct cost. Indirect costs and quality of life would positively be impacted as well.	**5**
Project Investment	Human resources – outreach, hiring the IM Equipment purchase and maintenance Legal and professional fees Time to implement – 1 year to establish baseline, 1 year to plan, 2 years to improve by 8% Risk assessment Organizational priorities – high Total value of this outcome/all category 3 outcomes: 19/61	**5**

197063401.3.2	*3.IT-1.7*	*CONTROLLING HIGH BLOOD PRESSURE*	
GPCH LLC Golden Plains Community Hospital			*197063401*
Related Category 1 or 2 Project Measure(s):		*197063401.1.2*	
Starting Point/Baseline:		**GPCH will establish a baseline of patients in Hutchinson County with high-blood pressure and the percentage of those identified with uncontrolled blood pressure, which GPCH will use to measure progress going forward**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-2 Establish a baseline by identifying patients in Hutchinson County suffering from high blood pressure, and how many of those patients do not have their condition under control Numerator: Number of patients in the denominator whose most recent BP is adequately controlled (less than 140/90) Denominator: Patients 18-85 years old with diagnosis of hypertension **Data Source:** Clinic and hospital E.H.R. **Milestone 1 Estimated Incentive Payment: $** 87,504	**Process Milestone 2: P-1** Project planning: establish an action plan, including the IM and other hospital/clinic staff for reaching out to patients with hypertension, best practices, and target number of interventions. Train staff accordingly. **Data Source:** Documentation of plan/training. **Milestone 2 Estimated Incentive Payment:** $ 122,663	**Outcome Improvement Target 1** **IT 1.7** **Improvement Target:** Control high blood pressure, with 4% increase over baseline Metric: Numerator: Number of patients in the denominator whose most recent BP is adequately controlled (less than 140/90) Denominator: Patients 18-85 years old with diagnosis of hypertension **Data Source:** E.H.R. of patients who visited the GPCH clinic/hospital. **Outcome Improvement Target 2 Estimated Incentive Payment:** $233,774	**Outcome Improvement Target 2** **IT 1.7** **Improvement Target:** Control high blood pressure, with 8% increase over baseline Metric: Numerator: Number of patients in the denominator whose most recent BP is adequately controlled (less than 140/90) Denominator: Patients 18-85 years old with diagnosis of hypertension **Data Source:** E.H.R. of patients who visited the GPCH clinic/hospital **Outcome Improvement Target 3 Estimated Incentive Payment:** $626,061
Year 2 Estimated Milestone Bundle Amount: $ 87,504	Year 3 Estimated Milestone Bundle Amount: $ 122,663	Year 4 Estimated Milestone Bundle Amount: $ 233,774	Year 5 Estimated Milestone Bundle Amount: $ 626,061
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,070,002			

Outcome Measure Title: IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores
Performing Provider: GOLDEN PLAINS COMMUNITY HOSPITAL/197063401
Unique Outcome ID: 197063401.3.3
Outcome Domain: OD 6: Patient Satisfaction

Outcome Measure Description:
Through the addition of an OB/Gyn to GPCH's clinic, the hospital expects improved health outcomes for pregnant women and their infants in Hutchinson County. By early and consistent access to an OB/Gyn (without having to travel over an hour to Amarillo), pregnant women are expected to have increased knowledge, support, and local assistance in maintaining a healthy pregnancy, which is expected to increase their satisfaction with the health care they receive during this critical time.

Project Goal: The overall goal of the project is to increase the satisfaction of pregnant women in Hutchinson County by 6%, by DY5. GPCH intends to make this happen through allowing patients to have local access to an OB/Gyn for reproductive care, meaning that patients no longer have to travel long distances for this important primary care.

Process milestones: DY 2 Project Planning (P1) and DY 3 Establish a Baseline (P2)
Improvement Target: DY4 3% increase in satisfaction (IT 6.1(1)) and DY5 additional 3% increase in satisfaction (IT 6.1(1))

Outcome Rationale:
The Region 12 Rural Community Needs Assessment reflected that 1/5 residents in the rural region cited lack of information about what services might be available as a reason they have difficulty accessing care. Thus, one aspect of achieving the target outcome will be to make sure that the community is aware of the addition of the new OB/Gyn, so they can utilize his/her services and receive medical information in a timely manner. Respondents from Hutchinson County stated that they often have to travel to Amarillo or Dumas to receive medical treatment, which they found difficult to do on a fixed income. This difficulty causes frustration, and thus adding a new provider to the community for an underserved population should lead to less difficulty and greater satisfaction with the availability of appointments locally. The need for OB/Gyn care is great in the community, and thus improving access is almost sure to improve patient satisfaction with receiving timely appointments, care, and information.
GPCH chose the process milestones for DY2-3 to allow time to identify a valid survey instrument, to train the clinic providers on administering these surveys, and to establish a baseline upon which to improve. GPCH chose the improvement targets it did by assessing how many patients would be likely to access to the OB/Gyn out of the total population of the clinic, and then how many would see increased satisfaction through the OB/Gyn.

Related Category 1 and/or 2 Project: 1.1.2 Expand Primary Care Capacity (OB/Gyn)

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	**Using a scoring system of 1-5, GPCH valued this project as follows:** GPCH's provision of patient centered care is meant to improve patient satisfaction, and this outcome is directly linked with that concept. Medicaid and uninsured often have the most difficult time obtaining care they can afford and access (as traveling is likely to be more difficult for these patients), thus adding a local provider should benefit this population greatly. Having a local OB/Gyn will allow for women's reproductive health to be coordinated with their other primary care, which should lead to increased satisfaction with the timeliness and level of information available and care provided. This project should improve patient satisfaction while reducing the need for patients to travel long distances for this care.	**5**
Addresses Community Needs	This project will address the following Region 12 Community Needs: CN.1 (Severe primary care provider shortage, wait time, expense, lack of insurance, access to care); CN.6 (Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam); CN.7 (Insufficient maternal and prenatal care, especially the first trimester teen pregnancy, high percentage of unmarried mothers); and CN.12 (High incidence of sexually transmitted disease). This project should result in better outcomes for each of the aforementioned issues by providing access, support, and screening for Hutchinson County residents.	**5**
Project Scope/Size	• Informing patients of the availability of the OB/Gyn, which should lead to increased timeliness in accessing appointments, care, and information locally, thereby increasing patient satisfaction • Requesting that patients fill out the patient satisfaction survey and explaining the justification for the survey • Training clinic staff to administer the survey	**4**
Project Investment	• Human resources – training • Equipment purchase and maintenance –survey instrument • Time to implement – two years Total value of this outcome/total value of all category 3 outcomes: 17/61	**3**

197063401.3.3	3.IT-6.1	PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES	
GPCH LLC Golden Plains Community Hospital			197063401
Related Category 1 or 2 Projects:	**197063401.1.3**		
Starting Point/Baseline:	**GPCH will establish a baseline of Borger clinic patients' satisfaction with their access to care, appointments and information in DY3, which GPCH will use to measure progress going forward**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: **P-1** Project planning: identify a valid, evidence-based survey to measure patient satisfaction with the timeliness of care, appointments, and information, and train GPCH providers to administer the survey to all GPCH clinic patients. **Data Source:** The survey identified and training materials **Milestone 1 Estimated Incentive Payment:** $ 78,293	**Process Milestone 2: P-2** Establish a baseline by identifying the average GPCH clinic patient's satisfaction with their access to timely appointments, care, and information. **Data Source:** Survey results of patients seen at GPCH and its clinics **Process Milestone 1 Estimated Incentive Payment:** $109,751	**Outcome Improvement Target 1** **IT 6.1(1)** **Improvement Target:** Improve patient satisfaction scores reflected in the targeted survey at GPCH's clinic by 3% over the baseline. Metric: Numerator: percent improvement in the targeted survey results. Denominator: number of patients administered the survey. **Metric:** Numerator: percent improvement in the targeted survey results. Denominator: number of patients administered the survey. **Data source:** survey results **Outcome Improvement Target 2 Estimated Incentive Payment:** $209,167	**Outcome Improvement Target 2** **IT 6.1(1):** **Improvement Target:** Improve patient satisfaction scores reflected in the targeted survey at GPCH's clinic by 6% over the baseline. Metric: Numerator: percent improvement in the targeted survey results. Denominator: number of patients administered the survey. **Data Source:** survey results **Outcome Improvement Target 3 Estimated Incentive Payment:** $560,160
Year 2 Estimated Outcome Amount: $78,293	Year 3 Estimated Outcome Amount: $109,751	Year 4 Estimated Outcome Amount: $209,167	Year 5 Estimated Outcome Amount: $560,159
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $957,371			

Outcome Measure Title: IT 9.2 Appropriate ED Utilization
Performing Provider: GOLDEN PLAINS COMMUNITY HOSPITAL/197063401
Unique Outcome ID: 197063401.3.4
Outcome Domain: OD-9 Right Care, Right Setting

Outcome Measure Description:
Through the addition of a separate space to treat non-emergent patients in the Emergency Department presenting with non-emergent conditions, GPCH expects a more appropriate (i.e. reduced) level of ED utilization overall. This project is tied to 2.8.6.

Project goal: Specifically, GPCH expects a 3% reduction in ED admissions for all patients in DY3 (under baseline), a 5% reduction in ED admissions for all patients in DY4 (under baseline), and a 7% reduction for all patients in DY5 (under baseline).

Process measure: establish baseline of all ED admissions for DY 2
Improvement targets: decrease all ED admissions at GPCH; 3% reduction in DY3, 5% reduction in DY4; 7% reduction in DY5.

Outcome Rationale:
In Rural Region 12, 5.2% of children below 19 years of age are uninsured, and 23% of residents went without health insurance for the last 12 months, as measured in 2010. These residents are much more likely to misuse the ED, as they have limited access to primary care in their communities (which is endemic statewide). In telephone surveys of residents in Rural Region 12, 4% admitted to using the ED when they are sick or need healthcare advice.

ED misuse is quite costly to the health care system, including at GPCH. Patients who present to the ED with non-emergent conditions are often patients without access to less-expensive care, who resort to using the ED in hopes that the hospital will not turn them away. Instead of treating these patients in the expensive emergency department, the hospital can provide treatment to these patients elsewhere and by lower-level staff, in order to save costs while protecting the health of these patients.

GPCH chose the process measure it did in order to establish a baseline, and chose the improvement targets in order to show meaningful improvement in the inappropriate use of the ED. GPCH crafted its improvement targets to allow for change that would have impact, but be reasonable considering GPCH's relative volume of patients. Baseline year of 9971 ED visits, would translate to a reduction of 698 ED Visit by DY 5. GPCH chose this achievement level because it experienced 782 non-emergent ED visits in 2012, meaning that this outcome would eliminate almost 90% of those non-emergent ED visits.

Related Category 1 and/or 2 project: Project 2.8.6 Improve Efficiencies: Reduce Inappropriate Emergency Department Use

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This Outcome Domain seeks to reduce the inappropriate use of the ED, thus reducing health care costs and enabling patients to receive care in the right setting. A reduction in misuse of the ED benefits all patients who may ultimately have an emergent condition and need the ED to have the capacity to provide their care. Patients redirected out of the ED will be triaged to the hospital's on-site non-emergent service area, which will improve the level and coordination of the treatment they receive and will reduce costs for the hospital in providing their treatment.	**5**
Addresses Community Needs	This outcome addresses the following Region 12 Community Needs: CN.1 (Severe primary care provider shortage, wait time, expense, lack of insurance, access to care) and CN.2 (Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact). This outcome is meant to address the misuse of the ED for non-emergent physical and mental health needs by providing alternative service delivery areas.	**3**
Project Scope/Size	• Outreach to let patients know there are other options for care at the hospital, outside of the ED • A 7% reduction in ED use, which will allow funds to be redirected to the new non-emergent service area • RNs will need to be recruited and/or trained to run the service area • In DY 5 alone, a savings of $205,880 is projected to result from the decreases visits	**3**
Project Investment	• Human resources – training/recruiting RNs and providers to direct patients out of the ED into the new service area • Equipment purchase and maintenance – create new service area within hospital; will need additional equipment • Time to implement – 1 year to set baseline, 3 years to improve misuse by 7% • Risk assessment – EMTALA concerns Total value of this outcome/Total value of all Category 3 outcomes: 15/61	**4**

197063401.3.4	3.IT-.9.2	ED APPROPRIATE UTILIZATION	
GPCH LLC Golden Plains Community Hospital			197063401
Related Category 1 or 2 Project(s):	197063401.2.1		
Starting Point/Baseline:	GPCH will establish a baseline of non-emergent ED visits by Hutchinson County residents during DY2, which GPCH will use to measure progress going forward		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish a baseline by identifying the number of non-emergent ED visits at GPCH from residents of Hutchinson County. Numerator: Number of non-emergent ED visits Denominator: All ED visits. **Data Source:** E.H.R. and ED records showing the number of patients seeking care at the ED, and the number that were ultimately deemed non-emergent **Milestone 1 Estimated Incentive Payment*:* $** 69,082	**Outcome Improvement Target 1** **IT 9.2** **Improvement Target:** Reduce all ED visits from residents of Hutchinson County by 3% over baseline. Metric: Numerator: number of ED visits in DY3 Denominator: Baseline number of ED visits **Data Source:** E.H.R. and ED records of visits and admits **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 96,840	**Outcome Improvement Target 2** **IT 9.2** **Improvement Target:** Reduce all ED visits from residents of Hutchinson County by 5% over baseline. Metric: Numerator: number of ED visits in DY4 Denominator: Baseline number of ED visits **Data Source:** E.H.R. and ED records of visits and admits **Outcome Improvement Target 2 Estimated Incentive Payment:** $184,559	**Outcome Improvement Target 3** **IT 9.2** **Improvement Target:** Reduce all ED visits from residents of Hutchinson County by 7% over baseline. Metric: Numerator: number of ED visits in DY5 Denominator: Baseline number of ED visits **Data Source:** E.H.R. and ED records of visits and admits **Outcome Improvement Target 3 Estimated Incentive Payment:** **$**494,258
Year 2 Estimated Milestone Bundle Amount: $ 69,082	**Year 3 Estimated Milestone Bundle Amount:** $ 96,840	**Year 4 Estimated Milestone Bundle Amount:** $184,559	**Year 5 Estimated Milestone Bundle Amount:** $ 494,258
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $844,739			

Outcome Measure Title: IT-9.2 – ED Appropriate Utilization
Performing Provider: Golden Plains Community Hospital/197063401
Unique Outcome ID: 197063401.3.5 – **"PASS 2"**
Outcome Domain: OD-9 Right Care, Right Setting

- **Outcome Measure Description:**

Improvement Target Description: Through implementing the Medical Home Model in its community, GPCH intends to reduce all ED visits to its facility. By providing coordinated care in the community, which will enable patients to access preventative and primary care in an organized and timely manner, the inappropriate use of the ED should be reduced. Further, the escalation into an acute state of chronic diseases or other manageable conditions is expected to drop, also leading to the outcome of fewer ED visits.

To measure the outcome, GPCH will first establish baseline statistics to determine the overall number of ED visits per year, and how many of those ED visits were for non-emergent conditions. In coordination with establishing the medical home model, GPCH will measure ED visits over the years of the Waiver, and aim to achieve a 10% reduction in overall use of the ED.

- **Process Milestones:**
  - **DY2:** Develop and test data systems (so GPCH can properly measure inappropriate use of the ED)
  - **DY3:** Establish baseline (to measure improvement in DYs 4-5)
- **Outcome Improvement Targets for each year:**
  - **DY4:** Reduce all ED visits to GPCH's ED by 8% under baseline from DY3
  - **DY5:** Reduce all ED visits to GPCH's ED by 10% under baseline from DY3

To measure the outcome, GPCH will first establish baseline statistics to determine the overall number of ED visits per year, and how many of those ED visits were for non-emergent conditions. In coordination with establishing the medical home model, GPCH will measure ED visits over the years of the Waiver, and aim to achieve a 10% reduction in overall use of the ED.

- **Rationale:**

GPCH chose this outcome because Hutchinson County is a federally designated Health Professional Shortage Area, especially in the area of primary care providers. Thus, the providers in place must be organized and coordinated in order to reach all members of the community in need of care and prevent patients from resorting to the ED as their first stop for primary care. Overuse of the ED is linked to a lack of access to coordinated care; thus, by solving the lack of access to coordinated care, GPCH expects the logical outcome of reduced ED use.

In 2012, the GPCH ED provided almost 10,000 encounters, of which approximately 4500 were Medicaid/self-pay. Approximately 800 of the ED visits were characterized as Level 1 or 2 (non-emergent), and GPCH hopes to reduce both emergent and non-emergent ED visits by increasing access to a medical home for indigent patients.

- **Outcome Measure Valuation:**

The valuation of each GPCH project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. GPCH valued this project as it did because it is an important outcome, which addresses costs, patient short-term and long-term health outcomes, and will benefit a large block of the population in Hutchinson County.

Valuation scores (1-5 scale)

Addresses Triple Aims of the Waiver: 4 (fewer unnecessary visits to the ED reduces the institutional cost of providing care in Hutchinson County and Region 12 overall)

Addresses Community Needs: 4 (the shortage of primary care providers in the Hutchinson County community results in a 33% misuse of the ED)

Project Size/Scope: 3 (this outcome will improve outcomes and costs for patients that routinely misuse the ED, which is about 1/3 patients presenting at the ED)

Project Investment: 3 (developing and implementing a plan will take time and resources; staff will require training, and additional technological tools may be necessary for coordination)

197063401.3.5 – "PASS 2"	**3.IT-9.2**	**ED Appropriate Utilization**	
Golden Plains Community Hospital			**197063401**
Related Category 1 or 2 Projects:	*197063401.2.2*		
Starting Point/Baseline:	*TBD DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 (P-3) Develop and test data systems for tracking non-emergent use of the ED, including the cost, the resident status of patients presenting at the ED, and how many are enrolled in medical homes. *Process milestone 1 estimated incentive payment: $57,505*	Process Milestone 2 (P-2) Establish a baseline of total visits to the GPCH ED over a year, and determine how many of those were for non-emergent conditions. *Process milestone 2 estimated incentive payment: $63,809*	Outcome Improvement Target 1 [IT 9.2] Target: reduce all GPCH ED Visits by 8% Metric: Numerator: DY4 ED visits Denominator: DY2 ED visits Data source: EHR *Improvement Target 1 Estimated Incentive Payment: $97,439*	Outcome Improvement Target 2 [IT 9.2] Target: reduce all GPCH ED Visits by 10% Metric: Numerator: DY5 ED visits Denominator: DY2 ED visits Data source: EHR *Improvement Target 2 Estimated Incentive Payment: $224,017*
Year 2 Estimated Outcome Amount: $57,505	**Year 3 Estimated Outcome Amount:** $63,809	**Year 4 Estimated Outcome Amount:** $97,439	**Year 5 Estimated Outcome Amount:** $224,017
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $442,770			

Outcome Measure Title: IT-6.1 Percent improvement over baseline of patient's satisfaction scores
Performing Provider Name/TPI: Hansford County Hospital District/094117105
Unique Outcome Measure ID: 094117105.3.1

Outcome Measure Description:

Improvement Target – IT 6.1 Percent improvement over baseline of patient's satisfaction scores of patient's administered the survey

Process Milestones –

DY2:

- P-1 Project planning – engage stakeholders, indentify current capacity and needed resources, determine timelines and document implementation plans

DY3:

- P-2 Establish baseline rates

Outcome Improvement Targets

DY4

- IT-6.1 Percent improvement over baseline of patient satisfaction scores. Improvement Target:TBD after baseline has been set

DY5

- IT-6.1 Percent improvement over baseline of patient satisfaction scores. Improvement Target:TBD after baseline has been set

Rationale:

DY 2 Process Milestones were chosen due to lack of accurate reports, access to information, and our current infrastructure isn't sufficient to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, project planning milestones and establishing baseline rates must be accomplished in DY2 and DY3

Due to lack of baseline data Improvement Target levels are TBD until process milestones in DY2 and DY3 have been completed.

Related Category 1 or 2 Projects

- 094117105.1.9

Outcome Measure Valuation Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project will ensure patients have access to primary care when they need it. Having access to primary care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to primary Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED.	**3**
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	**3**
Project Scope/Size	While there is opportunity to increase the total number of visits, the population of Hansford County is fairly small thus reducing the potential for significant savings as a result of this project.	**3**
Project Investment	The investment to complete this project will be minimal. We plan to utilize a firm that is currently conducting our HCAHPS survey for inpatients.	**2**

094117105.3.1	IT – 6.1	Percent improvement over baseline of patients satisfaction scores	
Hansford County Hospital District		094117105	
Related Category 1 or 2 Projects:	094117105.1.1		
Starting Point/Baseline:	Develop Plan and Documentation of plan		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning – engage stakeholders, indentify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $4,684	**Process Milestone 2: P-2** Establish baseline rates **Data Source:** Patient Satisfaction Survey **Estimated Milestone 2 Incentive Payment:** $5,430	Outcome Improvement Target 1: IT-6.1 Percent improvement over baseline of patient satisfaction scores. **Improvement Target:** TBD after baseline has been set **Data Source:** Patient Satisfaction Survey **Estimated Outcome Improvement Target 1 Incentive Payment:$**8,713	Outcome Improvement Target 2: IT-6.1 Percent improvement over baseline of patient satisfaction scores. **Improvement Target:** TBD after baseline has been set **Data Source:**Patient Satisfaction Survey **Estimated Outcome Improvement Target 2 Incentive Payment:$**20,835
DY 2 Estimated Outcome Amount *$4,684*	**DY 3 Estimated Outcome Amount:** *$5,430*	**DY 4 Estimated Outcome Amount:** *$8,713*	**DY 5 Estimated Outcome Amount***:* *$20,835*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$39,662*			

Outcome Measure Title: IT-6.1Percent improvement over baseline of patient's satisfaction scores. IT-6.1
Performing Provider Name/TPI: Hansford County Hospital District/094117105
Unique Project ID: 094117105.3.3 - "PASS 3b"
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

Improvement Target –

IT 6.1 Percent improvement over baseline of patient's satisfaction scores of patient's administered the survey

Process Milestones –

DY2:

- P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

- P-2 Establish baseline rates

Outcome Improvement Targets

DY4

- IT-6.1 Percent improvement over baseline of patient satisfaction scores by a TBD % after baseline has been set

DY5

- IT-6.1 Percent improvement over baseline of patient satisfaction scores by a TBD % after baseline has been set

Rationale:

DY 2 Process Milestones were chosen due to lack of accurate reports, access to information, and our current infrastructure isn't sufficient to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, project planning milestones and establishing baseline rates must be accomplished in DY2 and DY3

Due to lack of baseline data Improvement Target levels are TBD until process milestones in DY2 and DY3 have been completed.

Related Category 1 or 2 Projects

- 094117105.1.1

Outcome Measure Valuation Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project will ensure patients have access to primary care when they need it. Having access to primary care allows patients to receive the right care at the right time thus resulting in a more coordinated effort. This in turn reduces unnecessary visits to the ED thus reducing the cost to provide health care. By expanding the access to primary Medicaid and uninsured patients can receive care in a clinic setting as opposed to waiting to the last minute to receive care and end up in the ED.	**3**
Addresses Community Need(s)	This project addresses community needs identification # 1 of our community needs assessment, Severe primary care provider shortage, wait time, expense, lack of insurance, access to care.	**3**
Project Scope/Size	While there is opportunity to increase the total number of visits, the population of Hansford County is fairly small thus reducing the potential for significant savings as a result of this project.	**3**
Project Investment	The investment to complete this project will be minimal. We plan to utilize a firm that is currently conducting our HCAHPS survey for inpatients.	**2**

094117105.3.3 – "PASS 3b"	**3.IT–6.1**	**Percent improvement over baseline of patients satisfaction scores**	
Hansford County Hospital District		**094117105**	
Related Category 1 or 2 Project(s):	**094117105.1.3**		
Starting Point/Baseline:	**Baseline TBD during DY3**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $23,342	**Process Milestone 2**: P-2 Establish baseline rates **Data Source:** Patient Satisfaction Survey **Estimated Milestone 2 Incentive Payment**: $25,901	**Outcome Improvement Target 1**: IT-6.1 Percent improvement over baseline of patient satisfaction scores. **Improvement Target:** Improve Patient Satisfaction scores by a TBD percentage **Data Source:** Patient Satisfaction Survey **Estimated Outcome Improvement Target 1 Incentive Payment:$**39,552	**Outcome Improvement Target 2:** IT-6.1 Percent improvement over baseline of patient satisfaction scores. **Improvement Target:** Improve Patient Satisfaction scores by a TBD percentage. **Data Source:** Patient Satisfaction Survey **Estimated Outcome Improvement Target 2 Incentive Payment:$**90,933
DY 2 Estimated Outcome Amount $23,342	**DY 3 Estimated Outcome Amount:** $25,901	**DY 4 Estimated Outcome Amount:** $39,552	**DY 5 Estimated Outcome Amount:** $90,933
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $179,729			

Outcome Measure Title: IT-10.1 Quality of Life
Performing Provider: Helen Farabee Center /127373205
Unique Outcome Measure ID: 127373205.3.1

Outcome Measure Description:
The outcome measure is designed to track improvement in quality of life scores for Adults/Children with a single substance-abuse or dependence diagnosis who does not meet Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services as measured by the Substance Abuse Adult/Child Treatment Assessment. This is the assessment mandated by the Department of State Health Services and maintained in the Clinical Management for Behavioral Health Services (CMBHS) database. The assessment is a multi-purpose tool developed for adult and child substance abuse services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The assessment is considered comprehensive per competency guidelines outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA).[40]
The process milestones for DY2 and DY3 are "Disseminate findings, including lessons learned and best practices, to stakeholders". The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation.
The outcome improvement targets for DY4 and 5 are "Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment". The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients Childress, Cottle, King, and Dickens counties. The milestone increases to 10% for year 5.

Rationale:
The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in the region. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services. Modest achievement levels were selected since there is no current research specific to measuring quality of life improvements that are directly attributable to an open access model of care via the Substance Abuse Adult/Child Treatment Assessment.

[40] Center for Substance Abuse Treatment. *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.* Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 08-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006, reprinted 2007 and 2008, page 46.

Outcome Measure Valuation:
Substance abuse imposes a heavy burden on emergency room and primary care settings. When individuals are screened for substance abuse and receive appropriate treatment, the related utilization and abuse of health care settings will go down 50% with a savings of $3.81 to $4.30 for every dollar spent on treatment services. We used the average of $4.05 saved for every dollar spent on treatment services. The savings of $4.05 was determined by the Texas Drug Demand Reduction Advisory Committee Report to state leadership[41]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[41] Texas Drug Demand Reduction Advisory Committee: Report to State Leadership, January 2009 (http://www.dshs.state.tx.us/sa/ddrac/)

127373205.3.1	3.IT-10.1	*Quality of Life*	
The Helen Farabee Center			*[127373205]*
Related Category 1 or 2 Projects:	127373205.1.1		
Starting Point/Baseline:	***0 Substance Abuse services provided outside Wichita County to date.***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 1:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices **Data Source:** Service Activity Database and Meeting Minutes **Process Milestone 1 Estimated Incentive Payment***:* $5,235	**Process Milestone 2: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 2:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices **Data Source:** Service Activity Database and Meeting Minutes **Process Milestone 2 Estimated Incentive Payment *:*** $12,005	**Outcome Improvement Target 1: IT-10.1 Quality of Life-275,276,277 (*Standalone measure)*** **Improvement Target:** Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of the target population. **Data Source:** Substance Abuse Adult/Child Treatment Assessment. **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $12,837	**Outcome Improvement Target 2: IT-10.1 Quality of Life-275,276,277 (*Standalone measure)*** **Improvement Target:** Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 10% of the target population. **Data Source:** Substance Abuse Adult/Child Treatment Assessment. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $27,894
Year 2 Estimated Outcome Amount: $5,235	**Year 3 Estimated Outcome Amount:** $12,005	**Year 4 Estimated Outcome Amount:** $12,837	**Year 5 Estimated Outcome Amount:** $27,894
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $57,971			

Outcome Measure Title: IT-10.1 - Quality of Life
Performing Provider: Helen Farabee Centers/ 127373205
Unique Outcome Measure ID: 127373205.3.2
Outcome Domain: OD-10 Quality of Life/Functional Status

Outcome Measure Description:
The outcome measure is designed to track improvement in quality of life scores for Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders) as measured by the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths assessment (CANS). The ANSA and CANS are multi-purpose tools developed for adult and child behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. These tools are mandated for use by the Department of State Health Services within the Texas Recovery and Resiliency model of care.
The process milestones for DY2 and DY3 are "Disseminate findings, including lessons learned and best practices, to stakeholders". The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation.
The outcome improvement targets for DY4 and 5 are "Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA". The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the ANSA, for 5% of patients in Childress, Cottle, King, and Dickens County. The milestone increases to 10% for year 5.

Rationale:
The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in the region. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services. Modest achievement levels were selected since there is no current research specific to measuring quality of life improvements that are directly attributable to an open access model of care via the CANS/ANSA.

Outcome Measure Valuation:

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years. Based on the literature, an estimated Quality of Life Year gained by this intervention is 0.0245 years. Based on past performance in fiscal year 2012, we estimate demand for psychiatric evaluations to be 914 per year. The result is a valuation of $1,119,344 per year (914 x 0.0245 x $50,000). The valuation is aligned with the Medicaid Waiver goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research). Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The number of life-years added is based on a review of the scientific literature. A search of the scientific literature identified the following two studies. The first study looked at telemedicine and mental health and was conducted by Pyne (2010) [42] which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010) [43] examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

[42] Pyne, J. M., Fortney, J. C., Tripathi, S. P., Maciejewski, M. L., Edlund, M. J., & Williams, D. K. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Arch Gen Psychiatry, 67*(8), 812-821.

[43] Hollinghurst, S., Peters, T. J., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomized controlled trial. *Br J Psychiatry, 197*(4), 297-304.

127373205.3.2	3.IT-10.1	*Quality of Life*	
The Helen Farabee Center			127373205
Related Category 1 or 2 Projects:	127373205.1.2		
Starting Point/Baseline:	*0 routine on demand psychiatric evaluations to date*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **<u>Metric 1:</u>** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices **Data Source:** Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment*:* $540	**Process Milestone 2: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders **<u>Metric 2:</u>** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices **Data Source:** Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment*:* $1383	**Outcome Improvement Target 1: IT-10.1 Quality of Life-275,276,277 (*Standalone measure)*** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 5% of the target population. **Data Source:** Adult Needs and Strengths Assessment Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,485	**Outcome Improvement Target 2: IT-10.1 Quality of Life-275,276,277 (*Standalone measure)*** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 10% of the target population. **Data Source:** Adult Needs and Strengths Assessment Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,240
Year 2 Estimated Outcome Amount: $540	Year 3 Estimated Outcome Amount: $1,383	Year 4 Estimated Outcome Amount: $1,485	Year 5 Estimated Outcome Amount: $3,240
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,648			

Outcome Measure Title: IT- 6.1 – Percent Improvement over Baseline of Patient Satisfaction Scores

Performing Provider: Hemphill County Hospital/109588703

RHP Outcome Identification Number: 109588703.3.1

Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

IT-6.1.1 Getting timely care, appointments, and information

- Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services

- **Process Milestones:**
  - **DY2:**
    P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - **DY3:**
    P-2 Establish baseline rates

- **Outcome Improvement Target(s) for each year:**
  - **DY4:**
    IT-6.1 Percent improvement over baseline of patient satisfaction scores for (1) getting timely care, appointments, and information - Exact % TBD after establishing our baseline.
  - **DY5:**
    IT-6.1 Continue percent improvement over baseline of patient satisfaction scores for (1) getting timely care, appointments, and information – Exact % TBD after establishing our baseline.

Rationale:

Process Milestones – P-1 and P-2 were chosen so we can develop a fundamental process. This will include engaging stakeholders, developing plans including the implementation process as well as identifying the current capacity and the resources needed. Once developed, we will begin enrolling patients as well as providers in the program. We will also be developing educational classes that will best fit the needs of our region and promote and coordinate the appropriate community resources. In order to report accurate data and establish baselines, P-1 and P-2 must be approached in DY2-DY3. In DY-3 we will establish our baseline for improvement measure.

Improvement Target – This improvement target was chosen based on the timeframe in which the intervention will occur and for what is achievable during the start-up period of a patient navigation program. This outcome measure being addressed is largely affected by social determinants other than encounters with navigators. For instance, psychosocial and mental health issues, transportation issues, cultural and behavioral issues, and childcare issues will affect a patient's show rate for appointments, education, and getting timely care.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project achieves waiver goals by utilizing a community health worker as a patient navigator to provide enhanced support to vulnerable and/or high-risk patients. It will also improve the knowledge base of providers as well as of patients, improve coordination among providers and patients, and will initiate active follow-up to ensure positive outcomes. Enhancing the patients' abilities to manage their own illnesses by gaining trust in the CHW. The Patient Care Navigation Program addresses the health care needs of those who are most vulnerable and/or high risk and should allow us to be able to prevent unnecessary ED visits, connect patients to primary care, and promote a healthier population.	**5**
Addresses Community Need(s)	The Patient Care Navigation Program will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. This project will meet the Community Needs (CN) by targeting the following: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN3- Poor insurance support or uninsured. CN4- High incidence of obesity, diabetes mellitus and heart disease CN10- High prevalence of asthma and care issues RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.3 and CN.4 have been defined as *Urgent Needs*, and CN.10 falls in the category of *Important Need But Less Urgent.*	**5**
Project Scope/Size	Hemphill County has a lot of transient workers who have no PCP in this area. There are also area residents who are not established with a PCP. By implementing a community health worker to assist and support the patients with navigation services, support for disease management and education will be imperative. Implementation will include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Social Worker, as well as guest speakers to support these patients navigating through the project.	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Navigation Program so our investment for this project will involve a large amount of time spent in development, education and training. Currently, we do not employ a community health worker and would incur costs of filling this position and possibly others. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**4**

109588703.3.1	3.IT-6.1	Percent Improvement over Baseline of Patient Satisfaction Scores	
Hemphill County Hospital		**109588703**	
Related Category 1 or 2 project(s):	**109588703.2.1**		
Starting Point/Baseline: **0**	**To be determined in DY3**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Milestone 1: [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans ***Data Source:*** Outline of plan ***Estimated Milestone 1 Incentive Payment:*** $2,069	***Milestone 2: [P-2]*** **Establish baseline rates** ***Data Source:*** Data from the evidence based survey tool ***Estimated Milestone 2 Incentive Payment:*** $2,398	**Outcome Improvement Target 1: [IT-6.1]** Percent improvement over baseline of patient satisfaction scores Improvement Target: Increase patient satisfaction by 2 basis points – overall rating on the ED post-discharge NRC Picker patient satisfaction survey. ***Data Source:*** Data from the evidence based survey tool ***Estimated Outcome Improvement Target 1 Payment:*** $3,848	**Outcome Improvement Target 2:** **[IT-6.1]** Percent improvement over baseline of patient satisfaction scores Improvement Target: Increase patient satisfaction by 2 basis points in overall rating on the ED post-discharge NRC Picker patient satisfaction survey ***Data Source:*** Data from the evidence based survey tool ***Estimated Outcome Improvement Target 2 Payment:*** $9,202
DY 2 Estimated Milestone Amount: $2,069	**DY 3 Estimated Milestone Amount:** $2,398	**DY 4 Estimated Outcome Improvement Amount:** $3,848	**DY 5 Estimated Outcome Improvement Amount:** $9,202
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $17,517			

Outcome Measure Title: IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores

Performing Provider: Hereford Regional Medical Center/133544006

RHP Outcome ID: 133544006.3.1

Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

IT-6.1 - percent improvement over baseline for patient satisfaction scores.

- Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool.

Process Milestones:

- DY 2
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 Develop and test data systems

- DY 3
  - P-2 Establish baseline rates for 1) getting timely care; 2) appointments; 3)information
  - P-3 Develop and test data systems

Outcome Improvement Targets for each year:

- DY 4
  - IT-6.1: Improve patient satisfaction scores for timely care, appointments, information and physician/practitioner care by 2% over baseline.
- DY 5
  - IT-6.1: Improve patient satisfaction scores for timely care, appointments, information and physician/practitioner care by 3% over baseline.

Rationale: Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor are patients getting timely care, appointments and information concerning their visit to the clinic. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines for

1) are patients getting timely care, 2) appointments, and 3) information. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish baselines.

Improvement targets identified in DY4 and DY5 were chosen based on the timeframe in which the patient was able to get timely care, appointments and information based totally on patient's expectations and feedback obtained from them. The rationale for the patient satisfaction scores is to improve our existing processes in the primary care clinic as well as integrate the additional primary care physicians and practitioners being hired with the Category 1 project over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient. Currently, there is no method or process in place to measure patient satisfaction within our clinic.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The Waiver goals for this project are to improve patient satisfaction through the integration of additional primary care physicians and practitioners (Category 1 Expand Primary Care Capacity) being hired over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient as well as making primary care more readily available.	**4**
Addresses Community Need(s)	Deaf Smith County is nationally recognized as a Health Provider Shortage Area (HPSA) so the recruitment and retention of new and existing primary care providers is an imperative for the county and the region. The greatest healthcare challenge faced by Deaf Smith County and the region is the shortage of primary care physicians nationwide with the gap of what is needed and supplied widening. According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. More primary care physicians are a badly needed asset for the present and the future of RHP Region 12 rural communities. The most glaring evidence of the challenges facing rural communities in Region 12 is the number of primary care practitioners currently providing services to our population. In 2007, the state ratio of total persons to each direct patient care and primary care physician was 386. In comparison the ratio is 991.1 residents per direct patient care and primary care physician for Region 12. Currently in Deaf Smith County, according to the 2010 census, the population is 19,372. With the current number of primary care physicians and practitioners that translates to a ratio of 1761 persons to every primary care physician and practitioner. The implementation of the patient satisfaction survey for clinic patients will help ensure that the patients seeking primary healthcare in the clinic will have their needs and expectations met.	**4**
Project Scope/Size	This Category 3 project in improving patient satisfaction ranks second in the benefit to primary care expansion (Category 1 Project). The targeted population will not only realize the benefits to easier access to primary care, but also receiving the most value for their healthcare dollar. The targeted population will be the patients utilizing the clinic which will increase with the addition of three more primary care physicians and practitioner to the clinic. Patient will also be more able to avoid seeking primary healthcare outside of the	**4**

	clinic, because of the availability of addition practitioners.	
Project Investment	The investment in this project is an estimate at of around $700,000. DY 2 will have the upfront initial investment of searching and testing the myriad of survey options to determine the most economical method to obtaining the required baseline data. No more than $90,000 will be utilized in determining the method for data collection from patient satisfaction surveys. DY 3 will have an investment of no more than $125,000 to develop a baseline for the surveys. DY4 will be the first full year of data collection that will be used to improve healthcare value as well as patient satisfaction. No more than $170,000 will be invested in DY 3. In the last year of the project, DY 4, the investment for the project will increase to no more than $315,000. The increase in investment is attributed to the success of the Category 1 project and the addition of three more primary care physicians and practitioners.	**4**

133544006.3.1	***3.IT-6.1***	***Percent Improvement over Baseline of Patient Satisfaction Scores***	
Hereford Regional Medical Center		***133544006***	
Related Category 1 or 2 Project(s):		***133544006.1.1***	
Starting Point/Baseline: No Baseline at this time		***To be determined***	
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source**: EHR and engagement notes **Process Milestone 1 Estimated Incentive Payment:** $26,815.50 Process Milestone 2: [P-3] Develop and test data systems Data Source: Data systems tested or developed Process Milestone 2 Estimated Incentive Payment: $26,815.50	Process Milestone 3: [P-2] Establish baseline rates for 1) getting timely care; 2) appointments; 3)information **Data Source:** EHR; Business Intelligence Data System	Outcome Improvement Target 1: **[IT-6.1] percent improvement over baseline for patient satisfaction scores.** **Improvement Target:** Improvement over baseline established in DY3 of 2% for each (1) getting timely care, (2) appointments, and (3) information. **Data Source:** Survey Tool Selected in DY 2 **Estimated Outcome Improvement Target 1 Incentive Payment:$**99,753	Outcome Improvement Target 2: **[IT-6.1] percent improvement over baseline for patient satisfaction scores.** **Improvement Target:** Improvement over baseline established in DY3 of 5% for each (1) getting timely care, (2) appointments, and (3) information. **Data Source:** Survey Tool Selected in DY 2 **Estimated Outcome Improvement Target 2 Incentive Payment:$**238,540
DY 2 Estimated Outcome Amount: $53,631	**DY 3 Estimated Outcome Amount: $62,165**	**DY 4 Estimated Outcome Amount: $99,753**	**DY 5 Estimated Outcome Amount: $238,540**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $454,089			

Outcome Measure Title: IT-6.1 Percent Improvement over baseline of Patient Satisfaction scores
Performing Provider: Hereford Regional Medical Center/133544006
Unique RHP Outcome Identification number(s): 133544006.3.2 – **"PASS 2"**
Outcome Domain: OD-6 Patient Satisfaction

- **Outcome Measure Description:** The outcome measure for Category 3 is IT-6.1 percent improvement over baseline for patient satisfaction scores. The milestone for DY 2 is to identify a method/company/software to gather data on a patient getting timely care, appointments, and information. DY 3 milestone is the implementation of the tool to gather the information from patients on how timely their care was, how easy it is to obtain an appointment, the quality of the information given. DY 3 implementation process will set baseline data for DY 4 and DY 5 comparisons. DY 4 improvement target is to improve patient satisfaction scores for timely care, appointments, information by 2% over baseline. DY 5 improvement target is to improve patient satisfaction scores for timely care, appointments, information by 3% over baseline.
- Process Milestones
  - DY2
    - [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - [P-3]: Develop and test data systems.
  - DY3
    - [P-2]: Establish baseline rates.
  - DY5
    - [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders.

- Outcome Improvement Targets
  - DY4
    - IT-6.1: Improve patient satisfaction scores for timely care, appointments, information and physician/practitioner care by 2% over baseline.
  - DY 5
    - IT-6.1: Improve patient satisfaction scores for timely care, appointments, information and physician/practitioner care by 5% over baseline.

Rationale: Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor are patients getting timely care, appointments and information concerning their visit to the clinic. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines for 1) are patients getting timely care, 2) appointments, and 3) information.

Improvement targets identified in DY4 and DY5 were chosen based on the timeframe in which the patient was able to get timely care, appointments and information based totally on patient's expectations and feedback obtained from them. The rationale for the patient satisfaction scores is to improve our existing processes in the clinic as well as integrate the addition of a behavioral health provider hired with the Category 1 project over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient. Currently, there is no method or process in place to measure patient satisfaction within our clinic.

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Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The Waiver goals for this project are to improve patient satisfaction through the integration of adding a behavioral health practitioner (Category 1 Enhance service availability to appropriate levels of behavioral health) over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient as well as making primary care more readily available.	**2**
Addresses Community Need(s)	According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. The complete lack of a trained mental health provider will only be exacerbated over the coming years with additional increase in projected population. Also, according to the Needs Assessment for Region 12, the poverty level is higher (16.6% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Deaf Smith County residents puts them at a far greater risk for mental health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development. An addition of a mental health practitioner will directly impact the accessibility of lower socioeconomic patients to mental health.	**2**

Project Scope/Size	This Category 3 project in improving patient satisfaction ranks low in the benefit to be realized with primary care expansion (Category 1 Project). The targeted population will not only realize the benefits to increasing access to behavioral health care, but also receiving the most value for their healthcare dollar. The targeted population will be the patients needed behavioral health care in Deaf Smith County. Currently, there are not behavioral health services provided in the county.	**2**
Project Investment	Relative to our other proposed projects the expected investment will be relatively small. Our Pass 1 category 3 projects are selected to determine a method of tracking customer service for Behavioral Health Care Patients and improving on our patients satisfaction. The additional investment with this Category 3 project will be to determine with the same sample method for obtaining quality patient satisfaction information using the same process or procedure as the primary care process/procedure. The investment in this project is an estimate at of around $75,000. DY 2 will have the upfront initial investment of searching and testing the myriad of survey options to determine the most economical method to obtaining the required baseline data. No more than $10,000 will be utilized in determining the method for data collection from patient satisfaction surveys. DY 3 will have an investment of no more than $10,000 to develop a baseline for the surveys. DY4 will be the first full year of data collection that will be used to improve healthcare value as well as patient satisfaction. No more than $14,000 will be invested in DY 3. In the last year of the project, DY 4, the investment for the project will increase to no more than $32,000. The increase in investment is attributed to the success of identification and implementation of processes to improve patient satisfaction throughout the waiver period.	**2**

133544006.3.2 – "PASS 2"	***3.IT-6.1***	***Percent Improvement over baseline of patient satisfaction scores***	
Hereford Regional Medical Center			***133544006***
Related Category 1 or 2 Projects:	***133544006.1.2***		
Starting Point/Baseline:	***Baseline TBD in DY3***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: *Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.* **Data Source:** Documents. **Process Milestone 1 Estimated Incentive Payment:** $ 4,102.50 **Process Milestone 2 [P-3]:** Develop and test data systems. **Data Source:** Executed contract or survey. **Process Milestone 2 Estimated Incentive Payment:** $4,102.50	**Process Milestone 3 [P-2]:** *Establish baseline rates.* **Data Source:** *Hereford Regional Medical Center – Report Baseline* **Process Milestone 3 Estimated Incentive Payment:** $ 9,105	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement of baseline patient satisfaction scores **Improvement Target:** *Improvement over baseline established in DY3 of 2% for each (1) getting timely care, (2) appointments, and (3) information.* **Data Source:** *Survey Tool Selected in DY 2* **Outcome Improvement Target 2 Estimated Incentive Payment***:* $ 13,903	**Outcome Improvement Target 3** [IT-6.1]: Percent Improvement of baseline patient satisfaction scores **Improvement Target:** *Improvement over baseline established in DY3 of 5% for each (1) getting timely care, (2) appointments, and (3) information.* **Data Source:** *Survey Tool Selected in DY 2* **Outcome Improvement Target 3 Estimated Incentive Payment***:* $ 15,982 **Process Milestone 4** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders. **Data Source:** Documents **Process Milestone 4 Estimated Incentive Payment:** $15,982
Year 2 Estimated Outcome Amount: $ 8,205	**Year 3 Estimated Outcome Amount:** $ 9,105	**Year 4 Estimated Outcome Amount:** $ 13,903	**Year 5 Estimated Outcome Amount:** $ 31,964
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 63,177			

Outcome Measure Title: IT-6.1 Percent Improvement over baseline of patient satisfaction scores
Performing Provider: Hereford Regional Medical Center/133544006
Unique RHP Outcome Identification number(s): 133544006.3.4 – "PASS 3b"
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description: The outcome measure for Category 3 is percent improvement over baseline for patient overall health status/functional status. The milestone for DY 2 is to engage stakeholders, identify current capacity and need resources for the project. A method/company/software program to gather data on patient's overall health status/function will also need to be developed and tested. DY 3 milestone is the implementation of the tool to gather the information from patients on their overall health status/function status is. DY 3 implementation process will set baseline data for DY 4 and DY 5 comparisons. DY 4 improvement target is to improve patient satisfaction scores for patients overall health/function status by 2% over baseline. DY 5 improvement target is to improve patient satisfaction scores for patients overall health/function status by 5% over baseline.

- Process Milestones
  - DY2
    - [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - [P-3]: Develop and test data systems.
  - DY3
    - [P-2]: Establish baseline rates.
  - DY5
    - [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders.
- Outcome Improvement Targets
  - DY4
    - [IT-1.1]: Improvement over baseline established in DY3 of 2% for patient's overall health status/functional status.
  - DY5
    - [IT-1.1]: Improvement over baseline established in DY3 of 5% for patient's overall health status/functional status.

Rationale: Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor are patients getting timely care, appointments and information concerning their visit to the clinic. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines for 1) are patients getting timely care, 2) appointments, and 3) information.

Improvement targets identified in DY4 and DY5 were chosen based on the overall health status baseline of the patient and an overall improvement of status over the course of the waiver period. The rationale for the patient health status/functional status is to improve our existing processes in the our facilities as well as integrate the additional providers through our Category 1 and 2 projects into an overall redesign of our health system with an eye toward improving our patients overall health status/functional status. With this integration and successful identification of health status/functional status our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient. Currently, there is no method or process in place to measure patient health status/functional status within our patient population.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The Waiver goals for this project are to improve patient satisfaction over baseline through the redesign of our patient experience over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient as well as making primary care work more efficiently for the patient's overall health/functional statue.	**2**
Addresses Community Need(s)	According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. The complete lack of a trained mental health provider will only be exacerbated over the coming years with additional increase in projected population. Also, according to the Needs Assessment for Region 12, the poverty level is higher (16.6% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Deaf Smith County residents puts them at a far greater risk for mental health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development. An addition of a mental health practitioner will directly impact the accessibility of lower socioeconomic patients to mental health.	**2**
Project Scope/Size	This Category 3 project in improving patient satisfaction ranks a two when compared to the benefit to primary care expansion (Category 1 Project) and the redesign to improve Patient Experience (Category 2 Project). The targeted population will not only realize the benefits to easier access to primary care, but also receiving the most value for their healthcare dollar. The targeted population will be the patients utilizing the clinic which will increase with the addition of three more primary care physicians and practitioner to the clinic. Patient will also be more able to avoid seeking primary healthcare outside of the clinic, because of the availability of addition practitioners and the improvements made in patient experience.	**2**

Project Investment	Relative to our other proposed projects the expected investment will be relatively small. This Pass 2 Category 3 project is selected to determine a method of tracking customer service for Primary Care Patients and improving on our patient's satisfaction. The additional investment with this Category 3 project will be to determine with the same sample method for obtaining quality patient satisfaction information using the same process or procedure as the primary care process/procedure. The investment in this project is an estimate at of around $350,000. DY 2 will have the upfront initial investment of searching and testing the myriad of survey options to determine the most economical method to obtaining the required baseline data. The human resources needed will be substantial and extremely important to the success of the project The yearly cost of human resources will average anywhere from $50,000 to 150,000. As information is gathered it will need to be analyzed and disseminated to both internal and external stakeholders. No more than $10,000 will be utilized in determining the method for data collection from patient satisfaction surveys. DY 3 will have an investment of no more than $10,000 to develop a baseline for the surveys, but the human resources investment will be around $40,000. DY4 will be the first full year of data collection that will be used to improve healthcare value as well as patient satisfaction. No more than $100,000 will be invested in DY 4. In the last year of the project, DY 5, the investment for the project will increase to no more than $180,000 that will needed to analyze the information gathered and disseminate that information both visually and digitally. The increase in investment is attributed to the success of identification and implementation of processes to improve patient satisfaction throughout the waiver period.	**3**

133544006.3.4 – "PASS 3b"	*3.IT-6.1*	*Percent Improvement over Patient Satisfaction Scores*	
Hereford Regional Medical Center			*133544006*
Related Category 1 or 2 Projects:	*133544006.2.2*		
Starting Point/Baseline:	*Baseline TBD during DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Documents. **Process Milestone 1 Estimated Incentive Payment:** $ 22,626 **Process Milestone 2 [P-3]:** Develop and test data systems. **Data Source:** Executed contract or survey. **Process Milestone 2 Estimated Incentive Payment:** $22,626	**Process Milestone 3 [P-2]:** Establish baseline rates. **Data Source:** Hereford Regional Medical Center – Report Baseline **Process Milestone 3 Estimated Incentive Payment:** $ 50,212	**Outcome Improvement Target 1** [IT-6.1]: Improve patient satisfaction scores over baseline **Improvement Target:** Improvement over baseline established in DY3 of 2% for patient's overall health status/functional status **Data Source:** Survey Tool Selected in DY 2 **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 76,676	**Outcome Improvement Target 2** [IT-6.1]: Improve patient satisfaction scores over baseline **Improvement Target:** Improvement over baseline established in DY3 of 5% for patient's overall health status/functional status. **Data Source:** Survey Tool Selected in DY 2 **Outcome Improvement Target 3 Estimated Incentive Payment:** $ 88,141 **Process Milestone 4** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders. **Data Source:** Documents **Process Milestone 4 Estimated Incentive Payment:** $88,141
Year 2 Estimated Outcome Amount: $45,252	**Year 3 Estimated Outcome Amount:** $50,212	**Year 4 Estimated Outcome Amount:** $76,676	**Year 5 Estimated Outcome Amount:** $176,283
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $348,423			

Outcome Measure Title: IT-9.2 ED Appropriate Utilization

Performing Provider: Lubbock Heritage Hospital, LLC, dba Grace Medical Center

RHP Outcome ID: 281514401.3.1

Outcome Domain: OD-9 Right Care, Right Setting

Outcome Measure Description:

IT-9.2 ED appropriate utilization

- **Process Milestones:**
  - **DY2** P-2 Establish a benchmark for low acuity patient visits in the ED
  - **DY3** P-4 Conduct a Plan Do Study Act on a system for intervention on ED patients without a primary care providers which will include an assignment of primary care

- **Outcome Improvement Targets for each year:**

  Numerator: The number of visits to the walk-in clinic whose residence is in the HPSA zip codes of 79412, 79404, and 79423

  Denominator : The number of low acuity ED visits (triage level 4 or 5) who live in the identified target population zip codes

  - **DY4** IT- 9.2 ED appropriate utilization.
    - The ratio of visits at the new primary care walk-in clinic will show a ratio of greater than 1.0 and will be established as the baseline.
    - The low level ED visits will decrease by 5% over the target population baseline
  - **DY5** IT-9.2 ED appropriate utilization
    - The ratio of visits at the new primary care walk-in clinic will improve by 10% over the baseline
    - The low level ED visits will decrease by 10% over the target population baseline

Rationale: The process milestones established for Category 3 centered on planning for a new system to reduce acute, non-emergent emergency room visits (Triage Levels 4 and 5) due to lack of primary care access. The milestones include benchmarking, and performing a PDSA on a case management, patient assignment system for primary care. The outcome improvement targets

were based on the goal of Triple Aim by moving patients from seeking primary care in the emergency room into a primary care setting. The improvement targets include establishing a baseline of patients that visit the ER for primary care physician and decreasing future low acuity emergency visits while increasing visits to the primary care physician.

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	This project meets the RHP12 goal of Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. By providing additional primary care resources, case management, and electronic scheduling, Grace will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties. The project further develops and maintains a coordinated care delivery system. Right care improvement targets will allow better management of health in a cost effective location in a HPSA by moving patients out of low acuity ER visits into a primary care setting. There is a strong body of evidence that access to primary care and intervention in ER use improves care while reducing cost.	**5**
Addresses Community Need(s)	This project addresses RHP12's highest priority community need. Grace Medical Center is the only hospital located in a HSPA in the community. There is a strong body of evidence that access to primary care and intervention in ER use improves care while reducing cost.	**5**
Project Scope/Size	This project will include recruiting new primary care providers which will increase access to primary care in a HPSA neighborhood, thus increasing primary care visits and reducing ER visits. Neighborhood education will be utilized for outreach. The cost of a primary care visit is a fraction of the cost of an ER visits. This project will require the development of benchmarks and systems for intervention with ER patients.	**4**
Project Investment	This project will require the development of a new process which will require a new case management role, time to identify unassigned patients and measure the outcome of the intervention. It will be time consuming and require additional information technology linkages.	**3**

281514401.3.1	3.IT-9.2	ED Appropriate Utilization	
Lubbock Heritage Hospital, LLC, dba, Grace Medical Center		281514401	
Related Category 1 or 2 Projects:	281514401.1.1		
Starting Point/Baseline:	N/A		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	
Process Milestone 1: OD-9.P-2 Establish a benchmark for target population patient visits of low acuity in the ER . **Data Source**: ER visit registry **Process Milestone 1 Estimated Incentive Payment**: $67,582	**Process Milestone 3: OD-9.2.P-2** Conduct Plan Do Study Act on system for intervention of ER patients without ER doctor to provide assignment of primary care physician **Data Source:** Quality management documents, Primary Care patient schedule **Estimated Milestone 3 Incentive Payment**: $78,336	**Outcome Improvement Target 2:OD-9.IT-9.2** Improvement Target: Decrease of 5 % in low acuity ER visits from the baseline established in DY2. **Data Source** : ER visit reports, primary care provider volume reports **Estimated Outcome Improvement Target 2 Incentive Payment**:$125,702	**Outcome Improvement Target 2: OD-9.2.IT-9.2** Improvement Target: Decrease of 10% in low acuity ER visits from the baseline established in DY2. **Data Source:** ER visit reports, primary care provider volume reports **Estimated Outcome Improvement Target 3 Incentive Payment**:$300,592
DY 2 Estimated Outcome Amount: $67,582	DY 3 Estimated Outcome Amount: $78,336	DY 4 Estimated Outcome Amount: $125,702	DY 5 Estimated Outcome Amount: $300,592
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $572,212			

Outcome Measure: IT-2.1 Congestive Heart Failure Admission rate (CHF)

Performing Provider: Lamb Healthcare Center/127313803

RHP Outcome Identification Number: 127313803.3.1

Outcome Domain: OD-2 Potentially Preventable Admissions

Outcome Measure Description:

IT-2.1 Congestive Heart Failure Admission rate (CHF)

- All non-material discharges of age 18 years and older with a principle diagnosis code for CHF

Process Milestones:

- DY2)P-2 Establish baseline rates.

- DY3) P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Outcome Improvement Targets for each year:

- DY4) IT-2.1 Congestive Heart Failure Admissions rate (CHF) - Decrease admission rate by a percent TBD from baseline data established in DY2.

- DY5) IT-2.1 Congestive Heart Failure Admissions rate (CHF) - Decrease admission rate by a percent TBD from baseline data established in DY2.

Rationale:

Review chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. The Chronic care model has helped hundreds of providers improve care for people with chronic conditions. Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients.91 Also, an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained one or

more chronic care model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).92 Also, it has been shown that "planned care for all" can be more effective than "disease-silo" care. For example, the Cherokee Nation adopted a systems approach to diabetes care in 2002, which included many of the concepts in the Improving Patient Care (IPC) change package, such as patient and population management by registered nurse diabetes care managers; evidence-based guidelines; planned visits; care by a multidisciplinary team; diabetes self-management support and education; use of registries for population management; and data driven improvement, resulting in improved diabetes care and intermediate outcomes. Monitor all non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF.[44]
We chose P-2 Establish baseline rates and P-1 project planning due to lack or accurate reports and resources currently available to measure and monitor CHF in our system. We feel as though we need better data in order to determine the best way to make an improvement in our admission rates for CHF. Our improvement targets will be determined after DY2-3

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. The chronic care management model (CCMM) addresses the healthcare needs of all patients regardless of their financial resources. By implementing the CCM Model, we should be able to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. Chronic care models involve a multidisciplinary team to help foster a healthier lifestyle, compliance with medications and treatment plans, and offer support for those patients diagnosed with a chronic disease. The team will coordinate care, ensure follow-up with patients and providers and offer education to the community as a whole.	5
Addresses Community Need(s)	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. RHP 12 has identified Expanding Chronic Care Management as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN3- Poor insurance support or uninsured. RHP 12 has determined that CN.1 is considered a *Critical Need*, and CN.3 has been defined as *Urgent Need*,	**5**

[44] http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2008%20CHF%20Admission%20Rate.pdf

	The Chronic care model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.3	
Project Scope/Size	From 2008-2011, 349 adult residents (inpatient and outpatient) of Lamb County were diagnosed with a chronic disease resulting in Lamb Healthcare Center admitting 91 of these patients. These admissions were potentially preventable if the residents had increased access to care, had cooperated with appropriate healthcare, and had a multi-disciplinary support team to assist in monitoring and managing the chronic disease. We would implement a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic care model as well as invited expert speakers to support these patients navigating through the project.	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Chronic care model, so our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all members of our multi-disciplinary staff and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**4**

127313803.3.1	3.IT-2.1	Congestive Heart Failure Admission rate (CHF)	
Lamb Healthcare Center		**127313803**	
Related Cat 1 or 2 projects	**127313803.1.1**		
Starting Point/Baseline:	**To be developed**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Milestone 1: P-2- Establish baseline rate Data Source : EHR Estimated Milestone 1 Incentive Payment: $38,319	Milestone 2: P-1 Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of plan Estimated Milestone 2 Incentive Payment: $44,417	Milestone 3 **IT-2.1** **Congestive Heart Failure Admission rate (CHF)** Improvement Target Goal: Decreased admissions for CHF – exact % TBD after establishing baseline Data Source: EHR, Claims Estimated Milestone 3 Incentive Payment: $71,273	Milestone 4: **IT-2.1** **Congestive Heart Failure Admission rate (CHF)** Improvement Target Goal: Decreased admissions for CHF – exact % TBD after establishing baseline **Data Source:** EHR, Claims Estimated Milestone 5 Incentive Payment: $170,436
DY 2 Estimated Milestone Bundle Amount: $38,319	**DY 3 Estimated Milestone Bundle Amount:** $44,417	**DY4 Estimated Milestone Bundle Amount:** $ 71,273	**DY5 Estimated Milestone Bundle Amount:** $170,436
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: 324,445			

Outcome Measure Title: IT-9.2 ED Appropriate Utilization

Performing Provider: Lynn County Hospital District/094180903

Unique Outcome ID: 094180903.3.1

Outcome Domain: OD - 9 Right Care Right Setting

Outcome Measure Description:

IT-9.2 ED Appropriate

Reduce all ED visits

Process Milestones:

DY2:

P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-2 – Establish Baseline Rates

Outcome Improvement Targets for each year:

DY4:

IT-9.2 – Reduce all ED visits (including ACSC) by a TBD target improvement rate

DY5:

IT-9.2 – Reduce all ED visits (including ACSC) by a TBD target improvement rate

Rationale: Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our ED triage data/ED database to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because of the number of uninsured low income residents residing in our community. At this time there are approximately 60 clients enrolled in LCHD Indigent program and we plan to improve that amount by 10% each year.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Relative to your other proposed projects, to what extent does this project achieve the following waiver goals: Our project will ensure our indigent patients will have continuity of care and be assigned to a provider for their healthcare Our project will ensure our indigent patients will receive well checks and ongoing healthcare before their conditions worsen and they need ER care Our project will ensure that the Patient Navigator will be a constant coordinator between indigent patients and provider Our project will ensure low cost office clinic visits as opposed to high cost ER visits Performing Providers may consider the following attributes when scoring projects on this domain: Our project will definitely impact our goal of identifying and processing the indigent patients of Lynn County and giving them on-going well care with an assigned provider. Our project definitely impacts the Medicaid eligible and uninsured patients of Lynn County This project should increase our indigent numbers by 50% at the end of the project which should decrease the number of uninsured in our county There is strong evidence that clients regularly seen by one provider overseeing their care is much more effective than clients not having a primary care provider	**5**
Addresses Community Need(s)	Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at www.texasrhp12.com Performing Providers may consider the following attributes when scoring projects on this domain: Lynn County Hospital District is addressing the highest percentage of uninsured of Lynn County. Our county has a higher rate of uninsured than the majority of the rest of the region so we are focusing on identifying, processing and educating those people. Our project definitely impacts the Medicaid eligible and uninsured patients of Lynn County. This project should increase our indigent numbers by 50% at the end of the project which should decrease the number of uninsured in our county.	**5**
Project Scope/Size	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in: This project will be a major impact to our community and county. Our plan is to increase the indigent population by 10% each project year. We plan to host educational sessions, provide health fairs, flu vaccine clinics yearly and increase patient well checks to the clinic. Our Family Nurse Practitioners who staff the clinic are excited to be involved in this project. At this time, this clinic is sliding scale and this will reach a larger part of the community. We expect a decrease dramatically in the emergency visits from the county uninsured.	**5**

Project Investment	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: Our patient navigator will reach out to the uninsured thru follow-up clinic or emergency room visits and at this time we plan to hire one full-time Spanish speaking employee to be housed at the Family Wellness Clinic for overseeing the indigent program. This project will need an office area with a computer and telephone. This employee will be able to travel the county for education and will need an expense account for travel. This employee should have a strong desire to ensure the indigent clients feels comfortable and will be an advocate with the providers for the on-going care of the clients.	**5**

094180903.3.1	3.IT-9.2	ED Appropriate Utilization	
Lynn County Hospital District		094180903	
Related Category 1 or 2 Project(s):	094180903.2.1		
Starting Point/Baseline:	To be developed		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 **Project Planning -** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** meeting minutes, timelines and plan **Process Milestone 1 Estimated Incentive Payment:** $ 4,871	Process Milestone 2: P-2 Establish baseline **Data Source:** EHR Estimated Milestone 2 Incentive Payment: 5,646	**Outcome Improvement Target 1: IT-9.2** ED appropriate utilization **Improvement Target:** Decrease non-urgent ED use by TBD% **Data Source:** EHR **Estimated Outcome Improvement Target 1 Incentive Payment:$**9,060	**Outcome Improvement Target 2: IT-9.2** ED appropriate utilization **Improvement Target:** Decrease non-urgent ED use by TBD% **Data Source:** EHR **Estimated Outcome Improvement Target 2 Incentive Payment**:$ 21,665
DY 2 Estimated Outcome Amount: $4,871	**DY 3 Estimated Outcome Amount:** $5,646	**DY 4 Estimated Outcome Amount:** $9,060	**DY 5 Estimated Outcome Amount:** $ 21,665
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $41,242			

Outcome Measure Title: IT-6.1- Percent improvement over baseline of patient satisfaction scores

Performing Provider: Medical Arts Hospital/189947801

Unique RHP Outcome ID: 189947801.3.1

Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

IT-6.1 – Percent improvement over baseline of patient satisfaction scores.

- Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool.

Process Milestones:

- DY 2, our hospital will accomplish P-1 Project Planning.
- DY3, we will P-2 - establish baseline patient satisfaction scores by surveying our target population of established cardiology patients being seen for routine appointments in our specialty clinic.

Outcome Improvement Targets

- DY4 – IT-6.1 TBD Percent Improvement over baseline of patient satisfaction scores
- DY5 – IT-6.1 TBD Percent Improvement over baseline of patient satisfaction scores.

By the end of DY5 we will have improved the patient satisfaction scores among our target population of established cardiology patients being seen for routine appointments by an amount TBD through the use of telemedicine.

Rationale: Our hospital chose these process milestones because they accurately reflect a project in its infant stage. Tele-health is a new project; therefore, we must take the time in DY2 to plan. In DY3, our hospital will access our baseline patient satisfaction scores. Outcome improvement targets will be determined in DY2-3 for measurement in DY4. Our improvement milestone for the waiver is (I-12) is to increase the number of telemedicine visits for our target population by 15% over baseline in DY5. We chose to impact patient satisfaction through the use of telemedicine because our main goal is to increase access and we feel this can best be demonstrated by increasing the number of telemedicine consults. Our target population is established cardiology patients being seen for routine appointments through telemedicine. In 2011, we saw 330 of our target population of cardiology patients in in the specialty clinic with one physician coming one day per month. This physician averages 27 patients a day each time he visits our community. Our Community Needs Assessment states that in rural counties, like ours, 25% of households reported having a family member with some form of heart disease. In additions, Dawson County's mortality rate from Heart Disease is almost double the

State average. (258.4 deaths per 100,000 population as opposed to 154 per 100,000 population in Texas.) Starting with a baseline of 0% of cardiology patients receiving telemedicine consults, we plan to increase that to 15% or 50 cardiology consults per year in DY5 for our targeted population of established cardiology patients. Our target population of established cardiology patients being seen for routine appointments in 2011 was 330 patients. Of those patients, approximately 40% of those are on Medicare and 20% are Medicaid patients. Therefore, of the 50 visits increased over the life of the waiver, 30 of those will be for Medicare/Medicaid patients. This is a completely new initiative for this community and will require a great deal of education for our population that is older and less technically savvy. We understand that telemedicine is a priority issue for the U.S. Department of Health and Human Services, but we are not receiving any other funds related to offering this project. Expanded access to specialty care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	We valued this project as a 5 because it achieves the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. It will provide a great deal of impact for Medicaid and uninsured residents who have trouble traveling great distances to seek specialty care. For our targeted population, this project will move the dial greatly. Telemedicine has been widely studied and proven to show strong evidence that it achieves the triple aim.	**5**
Addresses Community Need(s)	We valued this project as a 4 because in relation to our other project it very effectively matches our Community Needs. Improving access to specialty care physicians in order to better manage chronic conditions was our number one Community Need. For the patients who use the telemedicine in the specialty clinic, their ability to manage their chronic condition will improve greatly. By removing the need to make expensive travel to see a cardiologist, low-income patients will see their physician more regularly and be more compliant. Telemedicine has been widely studied and proven to show strong evidence that it achieves the triple aim.	**4**
Project Scope/Size	In relation to our other project, this project will serve a larger population. Not only will it provide greater access to specialty care for cardiac patients, it will bring dozens of other greatly needed specialties to our community. We believe that increasing the local access to a cardiologist for our low-income patients will increase their ability to receive regular care to manage a chronic illness. These increased patient visits/encounters will yield better outcomes for the patients, saving both the patient and federal government.	**5**
Project Investment	In relation to our other project, this project provides the much desired pairing of cost-effective and highly impactful. It will provide services that "move the dial" while not requiring a great deal of capital. It can be implemented fairly quickly and is in line with the priorities of our organization.	**5**

189947801.3.1	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Medical Arts Hospital		189947801	
Related Category 1 or 2 Project(s):	189947801.1.1		
Starting Point/Baseline:	TBD in DY3		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Project plan **Process Milestone 1 Estimated Incentive Payment:** $23,915	**Process Milestone 2: P-2** Establish baseline rates of patient satisfaction rates. **Data Source:** Patient satisfaction results in target population of established cardiology patients receiving routine care in the specialty clinic prior to the introduction of telemedicine. **Process Milestone 2 Incentive Payment:** $27,720	**Outcome Improvement Target 1: IT-6.1** **Improvement Target:** Improvement in patient satisfaction scores among target population of established cardiology patients receiving routine care at the clinic through telemedicine. Amount of improvement TBD in DY2. **Data Source:** Patient satisfaction results in target population of established cardiology patients receiving routine care in the specialty clinic through telemedicine. **Estimated Outcome Improvement Target 1 Incentive Payment:$**44,482	**Outcome Improvement Target 2: IT-6.1** **Improvement Target:** Improvement in patient satisfaction scores among target population of established cardiology patients receiving routine care at the clinic through telemedicine. Amount of improvement TBD in DY2. **Data Source:** Patient satisfaction results in target population of established cardiology patients receiving routine care in the specialty clinic through telemedicine. **Estimated Outcome Improvement Target 2 Incentive Payment:$**106,369
DY 2 Estimated Outcome Amount: $23,915	**DY 3 Estimated Outcome Amount:** $27,720	**DY 4 Estimated Outcome Amount:** $44,482	**DY 5 Estimated Outcome Amount:** $106,369
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $202,486			

Outcome Measure Title: IT-3.2- Potentially Preventable Readmissions. CHF 30 day readmission rate

Performing Provider: Medical Arts Hospital/189947801

Unique RHP Outcome ID: 189947801.3.2

Outcome Domain: OD-3 Potentially Preventable Re-Admissions

Outcome Measure Description:

IT-3.2 - CHF 30-day readmission rate

- The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Process Milestones:

- DY 2, our hospital will accomplish **P-1 - Project Planning**.
- DY3, we will do **P-2 establish baseline** of CHF 30-day readmission among our current cardiac home health population before the implementation of tele-monitoring.

Outcome Improvement Targets for each year:

- DY4 – IT-3.2 Reduce Congestive Heart Failure 30 day readmission by a TBD amount
- DY5 – IT-3.2 Reduce Congestive Heart Failure 30 day readmission by a TBD amount

By the end of DY5 we will have decreased the number of potentially preventable CHF 30-day readmissions among cardiac patients requiring 24/7 monitoring by an amount TBD through the use of tele-monitoring in-home by Home Health.

Rationale:

Our hospital chose these process milestones because they accurately reflect a project in its infant stage. Tele-monitoring is a new project; therefore, we must take the time in DY2 to plan. In DY3, our hospital will access our baseline CHF 30-day readmission rates. Outcome improvement targets will be determined in DY2-3 for measurement in DY4. Our improvement milestone for the waiver is (I-12) to increase the number of patients for our target population by 6% over baseline in DY5. We chose to study CHF 30-Day readmission rates because we believe that the effectiveness of the tele-monitoring can best be measured in how we impact the 30-Day readmission rate. Our target population is cardiac patients requiring 24/7 monitoring in-home through Home Health. In 2011, our population of cardiac patients monitored by Home Health was 308 patients. Cardiac patients represent more than 50% of all Home Health patients total. 83% of all our Home Health patients are Medicare/Medicaid.

Our Community Needs Assessment states that in rural counties, like ours, 25% of households reported having a family member with some form of heart disease. In addition, Dawson County's mortality rate from heart related diseases is almost double the State average, (258.4 deaths per 100,000 populations as opposed to 154 per 100,000 population in Texas.) Starting with the baseline of 0% of home health cardiac patients utilizing tele-monitoring, we plan to increase that to 6% or 18 to 20 patients in DY5.
We will accomplish our five year waiver goals through the use of milestones. Milestone 1 is P-5, implement remote patient monitoring program based on evidence-based medical specialties such as Home Health. We chose this milestone (P-5) in DY2 because it matched our desire to begin this program as soon as possible in order to meet the documented need for a greater level of quality in the monitoring of our cardiac patients. Since this is a new program, we will benefit greatly from Process Milestone (P-11) when we participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Our improvement milestone for the waiver is (I-12) to increase the number patients in our target population using in-home tele-monitoring by 6%. Although the milestone stipulates number of visits, we are modifying that to demonstrate the increased number of users. Because this service is available 24/7, it is hard to clarify the number of "visits" performed by the health care team. We chose this milestone because our main goal is to increase the quality of the monitoring for our cardiac patients and we feel this can best be demonstrated by increasing the number of patients using the in-home tele-monitoring.

This is a completely new initiative for this community and will require a great deal of education for our population that is older and less technically savvy. We understand that telemedicine is a priority issue for the U.S. Department of Health and Human Services, but we are not receiving any other funds related to offering this project. Improving the quality of monitoring for cardiac patients is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	We valued this project as a 3 because while it does achieve the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way, it doesn't impact as large a population as our other project (1.7.1). It achieves all of the four stated waiver goals. It will provide a great deal of impact for the few Medicaid and uninsured patients who receive tele-monitoring in their home. For our targeted population, this project will move the dial greatly. Tele-monitoring has been widely studied and proven to show strong evidence that it achieves the triple aim.	**3**
Addresses Community Need(s)	We valued this project as a 2 because tele-monitoring was not specifically listed in our Dawson County Community Needs Assessment. However, improving the quality of care for those with chronic diseases was our greatest need and we believe this project will serve that need. Because it will impact a small population, it was graded lower than our other project (1.7.1).	**2**

Project Scope/Size	In relation to our other project, this project will serve a smaller population. This project was scored a 3 because it will achieve a great deal of outreach to our target population of cardiac patients that require 24/7 monitoring. Through the use of technology, a health-care professional can "be there" for the patient in a matter of seconds. It will provide 24/7 real time monitoring which is hard to equate to patient visits/encounters. We believe this project will lead to cost savings by preventing unnecessary ER visits and hospitalizations.	**3**
Project Investment	In relation to our other project, this project is more expensive and it impacts a smaller population. The cost of the in-home monitoring equipment and staff will be more extensive. This project also carries with it a greater risk for hospital, staff and patients. It will require an enormous amount of education to make sure that physicians feel comfortable with the results and patients understand how to utilize the equipment.	**3**

189947801.3.2	3.IT-3.2	Potentially Preventable Readmission Rates	
Medical Arts Hospital		189947801	
Related Category 1 or 2 Project(s):	189947801.1.2		
Starting Point/Baseline:	To be developed in DY3		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	
Process Milestone 1: P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Project plan **Process Milestone 1 Estimated Incentive Payment:** $15,474	**Process Milestone 2: P-2** Establish baseline rates of CHF 30-day Readmission Rates among all cardiac patients using Home Health. **Data Source:** claims based data **Estimated Milestone 2 Incentive Payment:** $17,937	**Outcome Improvement Target 1: IT-3.2 Congestive Heart Failure 30 day readmission rate** **Improvement Target:** Decrease in CHF 30-Day Readmission among target population of cardiac patients needing 24/7 monitoring in-home through Home Health. Amount of improvement TBD in DY2 **Data** Source: claims based data **Estimated Outcome Improvement Target 1 Incentive Payment:$**28,782	**Outcome Improvement Target 2: IT-3.2 Congestive Heart Failure 30 day readmission rate** **Improvement Target:** Decrease in CHF 30-Day Readmission among target population of cardiac patients needing 24/7 monitoring in-home through Home Health. Amount of improvement TBD in DY2 **Data Source:** claims based data Estimated Outcome Improvement Target 2 Incentive Payment:$68,827
DY 2 Estimated Outcome Amount: $15,474	**DY 3 Estimated Outcome Amount:** $17,937	**DY 4 Estimated Outcome Amount:** $28,782	**DY 5 Estimated Outcome Amount:** $68,827
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $131,020			

Outcome Measure Title: IT-6.1- Percent improvement over baseline of patient satisfaction scores

Performing Provider: Medical Arts Hospital/189947801

RHP Outcome Identification Number: 189947801.3.5 – "PASS 3b"

Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description: The Outcome Measure we selected isIT-6.1-percent improvement over baseline of patient satisfaction scores. In DY 2, our hospital will accomplish process measure, P-2, establishing baseline patient satisfaction rates prior to the expansion of the specialty care clinic. In DY3, we will accomplish project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. We will begin to work on Improvement Target (IT-6.1) that are TBD in DY2. By the end of DY5 we will have improved the patient satisfaction scores among our target population of Dawson County patients who choose to see a specialty physician at Medical Arts Specialty Clinic rather than travel to another clinic, by an amount to be determined in DY2.

Rationale: This project and its milestones will yield an outcome in OD-6 Patient Satisfaction. We selected this outcome measure because the satisfaction of our patients is a chief priority for our hospital. This project was selected because it represents a great need in Dawson County. Access to specialty care physicians was listed as one of our top priorities in the Dawson County Community Needs Assessment and is ranked as CN.1 in Region 12's assessment. Expansion of our specialty clinic will open our community to a broad range of specialties we would not be able to offer otherwise. In addition, it creates expanded appointment availability for our highest volume specialties; Cardiology, Dermatology and Gynecology. Our program will achieve all four of the core project components. We will (a) provide increased service availability with extended hours. We will do this by expanding the space so that we have two physicians practicing at the same time. The number of available service hours will be doubled by the expansion. We will also accomplish (b) increasing the number of specialty clinic locations. We will trade a grossly undersized clinic for a clinic twice the size. We will more than double the treatment space. The addition of a full-time Specialty Clinic Case Manager will help us address (c) implementation of transparent, standardized referrals across the system. And lastly, we will accomplish (d) conducting quality improvements for the project using methods such as rapid cycle improvements. We will do these through our participation in a learning collaborative with other providers in our region with a similar project. These activities are also addressed in our plan through process measure (P-21) where-in we will participate in face-to-face learning at least twice per year with other providers in the RHP to promote collaborative learning around shared or similar projects. The expansion of specialty care capacity will be accomplished through these process and improvement measures. In DY2 will train care providers and staff on processes, guidelines and technology for referrals (P-2). In DY2 we will also begin to participate in face-to-face learning with other providers in RHP with similar projects. We will continue this milestone (P-21) throughout the four years of this waiver. We chose these milestones in DY2

because they matched our need to learn from others and educate our own staff in how we can streamline the referral process in order to make the continuum of care seamless for our patients. In DY3 we plan to open our expanded specialty clinic. Not only will the clinic be twice the size of our current facility, it will be adjacent to our primary care clinic. We feel that the close proximity to one another will foster greater communication between the primary physician and staff and the specialty physician and staff. In DY4 we will begin focusing on our improvement milestone for the waiver, (I-23) to increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. We chose this milestone because our main goal is to increase access and we feel this can best be demonstrated by increasing the number of specialty visits .We will track our target population which is Dawson County patients choosing to see a specialty physician at the Medical Arts Specialty Clinic rather than travel to another clinic. The planning protocol states that we will improve over a baseline set in DY2. For the purpose of targeting our growth in DY4 and DY5, we calculated our growth based on encounter data in the specialty clinic from 10-1-11/10-31-12. In that year the clinic saw 1899 patients. We plan to increase that 40% or 759 specialty care visits in DY 4. In DY5, we plan to see an additional 1139 patients per year for an increase of 60%. We understand that expanding specialty care capacity is a priority issue for the U.S. Department of Health and Human Services, but we are not receiving any other funds related to offering this project. Expanded access to specialty care is one of Dawson County's greatest needs and therefore is addressed by Region 12 Community Needs Identifier CN.1.

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	We valued this project as a 5 because it achieves the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. It will provide a great deal of impact for Medicaid and uninsured residents who have trouble traveling great distances to seek specialty care. For our targeted population, this project will move the dial greatly. Increased access to specialty care has been proven to aid the management of chronic diseases.	**5**
Addresses Community Need(s)	We valued this project as a 5 because it very effectively matches our Community Needs. Improving access to specialty care physicians in order to better manage chronic conditions was our number one Community Need. For the patients who see physicians in our specialty clinic, their ability to manage their chronic condition will improve greatly. By removing the need to make expensive travel to see a specialist, low-income patients will see their physician more regularly and be more compliant. Improved access to specialty care achieves the triple aim.	**5**

Project Scope/Size	This project will serve a large number of patients in Dawson County. In 2012, 1899 patients were seen in our small rural specialty clinic. Not only will it provide greater access to specialty care for patients, it will give us the opportunity to expand our space so we can include greatly needed specialties to our community. We believe that increasing the local access to a specialty physician for our low-income patients will increase their ability to receive regular care to manage a chronic illness. These increased patient visits/encounters will yield better outcomes for the patients, saving both the patient and federal government.	**5**
Project Investment	This is our only project in Pass 2, therefore it was rated a 5. This project will require a large amount of capital to achieve the goal of doubling our specialty care clinic capacity. It will provide services that "move the dial" for our target population and for the uninsured/Medicaid population. This project will remove barriers to specialty care, provide choice and provide care that is patient centered.	**5**

189947801.3.5 – "PASS 3b"	3-IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Medical Arts Hospital		**189947801**	
Related Category 1 and/or 2 projects:	**189947801.1.5**		
Starting Point/Baseline:	**Baseline to be determined**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-2 Establish baseline rates of patient satisfaction rates. **Data Source:** Patient satisfaction results in target population: Dawson County patients choosing to seek specialty care at Medical Arts Specialty clinic rather than traveling to another clinic, prior to the launch of the expanded specialty clinic. **Estimated Milestone 1 Incentive Payment:** $28,652.	**Process Milestone 2: P-1** Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Project plan **Process Milestone 2 Estimated Incentive Payment:** $31,793	**Outcome Improvement Target 1: IT-6.1** Percent Improvement over baseline of patient satisfaction scores **Improvement Target:** Improvement in patient satisfaction scores among target population: Dawson County patients choosing to seek specialty care at Medical Arts Specialty clinic rather than traveling to another clinic Amount of improvement TBD in DY2. **Data Source:** Patient Survey **Estimated Outcome Improvement Target 1 Incentive Payment**:$ 48,549	**Outcome Improvement Target 1: IT-6.1** Percent Improvement over baseline of patient satisfaction scores **Improvement Target:** Improvement in patient satisfaction scores among target population: Dawson County patients choosing to seek specialty care at Medical Arts Specialty clinic rather than traveling to another clinic Amount of improvement TBD in DY2. **Data Source:** Patient Survey **Estimated Outcome Improvement Target 1 Incentive Payment:$** 111,618
DY 2 Estimated Outcome Amount: $28,652	**DY 3 Estimated Outcome Amount: :** $31,793	**DY 4 Estimated Outcome Amount:** $48,549	**DY 5 Estimated Outcome Amount:** $111,618
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:$220,612			

Project Title: IT-9.2- ED appropriate utilization

Performing Provider: Medical Arts Hospital/189947801

RHP Outcome Identification Number: 189947801.3.4 – **"PASS 3"**

Outcome Domain: OD-9 Right Care, Right Setting

- **Outcome Measure Description:**
  - **IT - 9.2- ED appropriate utilization**

    This project and its milestones will yield an outcome in OD-9 Right Care, Right Setting. We selected this outcome measure because the usage of our Emergency Department is unusually high. In 2010, Medical Arts Hospital had 7,882 ED visits. We know that many of these were for non-emergent conditions that should be taken care of in the clinic. We believe that we will see a reduction in ED visits during the time when clinic hours are extended. Patients will elect to seek care for non-emergent conditions in the clinic instead of utilizing the ED. Physicians and staff will be trained in how to triage patients with non-emergent conditions who do present at the ED. After an official triage in the ED, the physician will inform the patient that the clinic is open at this time and that treatment for a non-emergent condition should be sought there. This will help our target population, of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours; establish a relationship with a physician in our clinic. This will help these patients establish a medical home for their family, breaking the cycle of improper utilization of the ED. In DY2 we will work to establish a baseline of ED visits attributed to our target population prior to the commencement of the clinic's extended hours. We will compare the same hours of the day. Example: We will look at the average ED usage Saturday mornings from 9 am- 1 pm attributed to our target population prior to the opening of our Saturday primary care clinic then we will compare it to the same hours to see how many visits are attributed to our target population after the Saturday clinic was established. In DY3 we will engage in project planning (P-1). Beginning in DY 4, we will focus on Improvement Target (IT-9.2) that will reduce all ED visits during the time the primary care clinic is open during extended hours. We will continue to reduce those visits in DY5 by a percentage that is TBD in DY2. Our target population includes a large number of uninsured and Medicaid patients. We believe these extended clinic hours paired with culturally sensitive education and direction from the ED will move the dial greatly for this target population. That is why this project, the milestones and the outcome measures make sense for our community.

- **Rationale:** Our hospital chose these process milestones because they accurately reflect a project in its infant stage. Expanding our Primary Care Clinic hours is a new project for us. Therefore, we must take the time in DY2 to (P-2) establish a baseline of ED utilization among our target population prior to the offering of expanded clinic hours. In DY3, our hospital will take the time to

(P-1)consult all stakeholders and plan for all elements of transitioning to practices that will support Right Care, Right Setting during the time that the clinic is open for extended hours. A large part of that planning will include education and communication to patients who are accustomed to using the ED for primary care. It will take cooperation from all stakeholders to begin to change these behaviors. In DY4 we will begin to document a reduction in ED utilization among target population of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours. Improvement targets will be determined and documented in DY2. In DY5 we will continue the documentation of a reduction in ED utilization.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5	We valued this project as a 5 because it achieves the triple aim of assuring patients receive high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. It will provide a great deal of impact for Medicaid and uninsured residents who do not have a medical home and utilize the ED for primary care. For our targeted population of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours, this project will move the dial greatly. Extended hours in the clinic will allow them the opportunity to choose to seek the right care in the right setting.	**5**
Addresses Community Need(s) Scale: 1 to 5	We valued this project as a 5 it is our only project in this Pass 3 submission. Improving access to primary care physicians through the use of expanded clinic hours meets a great Community Need. This will help our target population, of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours; establish a relationship with a physician in our clinic. This will help these patients establish a medical home for their family, breaking the cycle of improper utilization of the ED. Expanded clinic hours will achieve the triple aim of providing high-quality, patient centered care in the most cost effective way.	**5**

Project Scope/Size Scale: 1 to 5	This project is rated a five due to the fact that it is our only project in Pass 3. This project will impact a great number of patients in our target population. By the end of the waiver period we expect that extra 900 patient visits per year will be offered through extended clinic hours. These clinic hours will directly benefit uninsured and Medicaid patients who may be receiving their primary care in the Emergency Department. These 900 extra visits will move the dial greatly for these most vulnerable members of our community who need a stable medical home.	**5**
Project Investment Scale: 1 to 5	This project provides the much desired pairing of cost-effective and highly impactful. It will provide services that "move the dial" without requiring a great deal of capital. This project is done using resources we already have. It can be implemented fairly quickly and is in line with the priorities of our organization.	**5**

189947801.3.4 – "PASS 3"	**3.IT-9.2**	**Right Care, Right Setting**	
Medical Arts Hospital		**189947801**	
Related Category 1 or 2 project	**189947801.1.4**		
Starting Point/Baseline:	**Baseline to be established in DY2**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-2 *Establish baseline rates of ED utilization* *prior to the commencement of the extended hours in the primary care clinic.* *Data Source: claims based data* Process Milestone 1 Estimated Incentive Payment: $7,653	Process Milestone 2: P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project plan *Estimated Milestone 2 Incentive Payment:* *$8,492*	*Outcome Improvement Target 1: IT-9.2* *ED Appropriate Utilization* ***Improvement Target**: Decrease ED Utilization among target population* of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours. *Amount of improvement TBD in DY2* *Data Source: claims based data* *Estimated Outcome Improvement Target 1 Incentive Payment:$12,968*	*Outcome Improvement Target 1: IT-9.2* *ED Appropriate Utilization* ***Improvement Target:** Decrease ED Utilization among target population* of Dawson County patients seeking primary care for a non-emergent illness during the extended clinic hours. *Amount of improvement TBD in DY2* *Data Source: claims based data* *Estimated Outcome Improvement Target 1 Incentive Payment:$29,813*
DY 2 Estimated Outcome Amount: $7,653	*DY 3 Estimated Outcome Amount: $8,492*	*DY 4 Estimated Outcome Amount: $12,968*	*DY 5 Estimated Outcome Amount: $29,813*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $58,926			

Outcome Measure Title: IT-1.11 Diabetes Care: BP Control (<140/80mm Hg) 234 – NQF 0061

Performing Provider: Memorial Hospital - Gaines/094212303

Unique RHP Outcome ID: 94212303.3.1

Outcome Domain: OD-1 Primary Care and Chronic Disease Management

Outcome Measure Description:

IT – 1.11 – Diabetes care: BP control (<140/80mmHg).

- Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.

Process Milestones:

- DY 2:
  - P-1 - Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-3 – Develop and test data systems
- DY 3
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
  - P-5 – Disseminate findings including learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY 4
  - IT-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (Standalone measure). Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg. Increase the percentage of accurate data collection by 50% over baseline. Increase the percentage of patient compliance by 20% over baseline.
- DY 5
  - IT-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (Standalone measure). Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg. Increase the percentage of accurate data collection by 30% over baseline. Increase the percentage of patient compliance by 20% over baseline.

Rationale:
Process Milestones P1 and P3 were chosen due to the need to identify resources and processes necessary to collect relevant data. An electronic system will need to be implemented and tested prior to full implementation of this outcome measure. Process Milestones P4 and P5 were chosen to support findings and support the intended outcome improvement targets.

Improvement Target 1.11 was chosen to support the overarching goal of the region to improve patient health and patient outcomes. Our project to expand access to primary care provides the opportunity to address this community, regional and national issue.

Related Category 1 or 2 Projects:
094121303.1.1

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	There are two entry points to healthcare, the primary care provider and the emergency room. The emergency room is the most costly means to provide primary care. Access to primary care providers in a clinic setting assures patients receive high-quality and patient-centered care, in the most cost effective ways. Diabetes has a significant presence in our community and across the nation. The cost of care associated with uncontrolled diabetes is high. Measuring the percent of diabetic patients successfully controlling their blood pressure will provide feedback indicating success of our project and a reduction negative effects that are associated with high blood pressure for diabetic patients.	**5**
Addresses Community Need(s)	Diabetes was a specific need expressed in our local community needs assessment. Diabetes was also identified as a urgent need in the regional assessment. Monitoring blood pressure and educating patients as to the importance of maintaining appropriate levels will help address this community need.	**5**
Project Scope/Size	This project provides the opportunity to increase diabetic patient encounters in which blood pressure is successfully managed. This project has the potential to impact a large part of the population as it can prevent complications in diabetic patients related to high blood pressure and it can help to diagnose diabetes and other chronic diseases.	**4**
Project Investment	Considering the time, personnel and electronic resources needed to implement this outcome measure, the initial investment will be significant. The investment required to continue monitoring will be minimal.	**4**

094121303.3.1	3.IT-1.11	Diabetes Care: BP Control (<140/80mm Hg) 234 – NQF 0061	
Memorial Hospital		094121303	
Related Category 1 or 2 Project(s):	094121303.1.1		
Starting Point/Baseline:	Baseline info: Baseline to be established in DY 4 as 0.		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015 – 9/30/2016)*
Process Milestone 1: P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Project Plan **Process Milestone 1 Estimated Incentive Payment:** $ 17,385.50 **Process Milestone 2: P-3** Develop and test data systems. **Data Source:** Data system **Process Milestone 2 Estimated Incentive Payment:** $ 17,385.50	**Process Milestone 3: P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source:** PDSA studies **Process Milestone 3 Estimated Incentive Payment:** $ 20,153. **Process Milestone 4: P-5** Disseminate findings including learned and best practices to stakeholders. **Data Source:** Data system **Process Milestone 4 Estimated Incentive Payment:** $ 20,152.	**Outcome Improvement Target 1: IT-1.11 Diabetes care: BP control (<140/80mmHg).** **Improvement Target:** Increase the percentage of patient with BP controlled by 20% over baseline. Expected increase in clinic patient visits increase is 1,500, thus expected impact of 300 patients. **Data Source:** E.H.R **Estimated Outcome Improvement Target1 Incentive Payment:** $ 64,675	**Outcome Improvement Target 2: IT-1.11 Diabetes care: BP control (<140/80mmHg).** **Improvement Target:** Increase the percentage of patient with BP controlled by 40% over baseline. Expected increase in clinic patient visits increase is 1,500, thus expected impact of 600 patients. **Data Source:** E.H.R **Estimated Outcome Improvement Target 2 Incentive Payment:** $ 154,659
DY 2 Estimated Outcome Amount: $ 34,771	**DY 3 Estimated Outcome Amount:** $ 40,305	**DY 4 Estimated Outcome Amount:** $ 64,675	**DY 5 Estimated Outcome Amount:** $ 154,659
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 294,410			

Outcome Measure Title: IT-1.7 – Controlling High Blood Pressure
Performing Provider: Memorial Hospital –Gaines/094121303
Unique RHP Project Identification number(s): 094121303.3.2 – **"PASS 2"**
Outcome Domain: OD – 1 - Primary Care and Chronic Disease Management

- **Outcome Measure Description:**
  IT1.7- Controlling high blood pressure. The number of patients in the denominator whose most recent blood pressure is adequately controlled (BP less than 140/90mmHg) during the measurement year.

- **Process Milestones:**
  - **DY 2:**
    - P-1 - Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-3 – Develop and test data systems
  - **DY 3:**
    - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 – Disseminate findings including learned and best practices to stakeholders.

- **Outcome Improvement Targets for each year:**
  - **DY4:**
    - IT-1.7 Controlling high blood pressure – The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90mm Hg) during the measurement year. Increase the percentage of accurate data collection by 50% over baseline. Project expected to impact 1,000 patients.
  - **DY5:**
    - IT-1.7 Controlling high blood pressure – The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90mm Hg) during the measurement year. Increase the percentage of accurate data collection by 50% over baseline. Project expected to impact 1,300 patients.

- **Rationale:**

- Process milestones P-1, P-3, P-4 and P-5 were selected due to the lack of access to information, infrastructure and systems to implement project Category 2, Project 2.11 – Medication Management. In order to establish baselines and report accurate data these process milestone must be approached in DY2 and DY3.
- Improvement target achievement levels have not yet been determined but IT-1.7 was chosen for the number of patients in the denominator whose most recent blood pressure is adequately controlled during the measurement year based on the fact that high blood pressure is an underlying cause to several chronic diseases. High blood pressure is often controlled through an appropriate medication regimen, therefore appropriate medication management can have a significant impact on controlling high blood pressure.

- **Related Category 1 or 2 Project:**
  - This project relates to Category 2.11 Conduct Medication Management for Memorial Hospital, 094121303.2.2.11.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project effectively achieves the triple aim of assuring patient receive high –quality, patient-centered care, in the most cost effective ways, by truly focusing on the individual patient and helping him/her to manage their illness through appropriate medication use avoiding the costly care associated with unmanaged chronic illness. Research conducted by the World Health Organization, Agency for Healthcare Research and Quality and Centers for Medicare and Medicaid Services all indicate that the ratio of dollars spent on medications to the positive impact on the costs and health outcomes is substantial. Given the utilization rates at Memorial Hospital, this project is expected to significantly impact Medicare, Medicaid and uninsured patients.	**5**
Addresses Community Need(s)	Controlling high blood pressure significantly addresses the local and regional community need related to chronic diseases (CN.4). Chronic diseases are prevalent in this area due to the socio-economic status of many of the area's residents. Patient education and effective medication management for controlling high blood pressure have the potential to move the dial towards healthier patients and cost-effective care.	**4**
Project Scope/Size	This project provides the opportunity to improve patient health outcomes and prevent unnecessary utilization of emergency room and/or acute care services. Monitoring of high blood pressure is expected to affect 3,000 patients annually at Memorial Hospital.	**5**
Project Investment	To successfully implement and sustain this project requires investment in educational materials, systems to capture and analyze data electronically and personnel to provide education and project quality improvement review. It is expected that the initial investment will be significant due to the need to capture data electronically. Initial investment will also include education of existing staff regarding implementation of this project. Maintenance of the project will require one employee to conduct quality improvement review and existing staff to provide patient education.	**4**

094121303.3.2 – "PASS 2"	*3.IT-1.7*	*Controlling High Blood Pressure*	
Memorial Hospital- Gaines			*094121303*
Related Category 1 or 2 Projects:	*094121303.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 - **P-1** - Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Written project plan. **Process Milestone 1 Estimated Incentive Payment***:* $2,660 **Process Milestone 2 P-3** – Develop and test data systems **Data Source:** Assessment tools and Electronic Health Record **Process Milestone 2 Estimated Incentive Payment:** $2,660	**Process Milestone 3 – P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source:** PDSA tools and/or other quality assessment tools. **Process Milestone 3 Estimated Incentive Payment:** $2,951.50 **Process Milestone 4- P-5** – Disseminate findings including learned and best practices to stakeholders. Data Source: PDSA tools and/or other quality assessment tools. **Process Milestone 4 Estimated Incentive Payment:** $2,951.50	**Outcome Improvement Target 1 - IT-1.7** Controlling high blood pressure **Improvement Target:** Increase the number of patients with BP controlled. Expected to impact 1,000 patients. **Data Source:** Electronic Health Record **Outcome Improvement Target 1 Estimated Incentive Payment***:* $9,014	**Outcome Improvement Target 2 - IT-1.7** Controlling high blood pressure **Improvement Target:** Increase the number of patients with BP controlled. Expected to impact 1,300 patients. **Data Source:** Electronic Health Record **Outcome Improvement Target 2 Estimated Incentive Payment***:* $20,724
Year 2 Estimated Outcome Amount: $5,320	**Year 3 Estimated Outcome Amount:** $5,903	**Year 4 Estimated Outcome Amount:** $9,014	**Year 5 Estimated Outcome Amount:** $20,724
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $40,962			

Outcome Measure Title: IT-1.7 Controlling High Blood Pressure
Performing Provider: Moore County Hospital District (Memorial Hospital)/094129602
Unique RHP Outcome ID: 094129602.3.1
Outcome Domain: OD-1 Primary Care and Chronic Disease Management

Outcome Measure Description:

IT-1.7 Controlling High Blood Pressure

- Increase the number of patients whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

The purpose of this outcome measure is to demonstrate an ability to decrease blood pressure of hypertensive patients within the practice of a newly recruited provider. This project correlates with Moore County Hospital District's Category 1 project to recruit a new primary care provider to its community.

Process Milestones:

- DY2-3
  - **Process Measure P-2** will be required to Establish Baseline Rates.

Outcome Improvement Targets for each year:

- DY4-5
  - **Improvement Target - IT-1.7** will be measured and reported. For this measure, the numerator will be the number of patients in the denominator whose most recent blood pressure is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator will be patients in the practice/clinic ages 18 to 85 as of December 31 of the measurement year with a diagnoses of hypertension. The data source will be the EHR for the practice/clinic. The goal will be to improve compliance from the previous year.

Rationale:
Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. In Texas, the rate is slightly less at 27.8 percent of the population, according to DSHS. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke, and renal failure; results are particularly striking in elderly hypertensives,

which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 to 20 percent reduction in mortality from coronary heart disease. Literature from clinical trials indicates that 53 to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and Joint National Committee. Process Milestone P-2 was chosen for this project because no current baselines data exists for the target population. Improvement Target IT-1.7 was selected for DY 4-5 because if between 27.8 and 33.5 percent of Moore County residents have hypertension, as studies suggest, this disease process is clearly a pressing community need that should be managed.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Achieves Waiver Goals: (5) Achieving the Triple Aim demands high-quality care, designed to meet the needs of patients, in ways that are cost efficient. As previously established, unmanaged hypertension has a deleterious long-term effect on health. As health deteriorates, costs rise. Thus, a focused effort to control hypertension within a patient population will naturally produce immediate health benefits for the patient and long-term benefits for healthcare costs. In 2011, Average Household Income in Moore County was $52,171. Moore County falls well below the State Average Household Income of $65,413 and the US Average Household Income of $67,529. Therefore, many of the patients who will necessarily be treated as a part of a MCHD-employed provider's practice will be low-income, including Medicaid.

Addresses Community Needs: (5) If between 27.8 and 33.5 percent of Moore County residents have hypertension, as studies suggest, this disease process is clearly a pressing community need that should be managed.

Project Scope/Size: (3) The size and scope of this project will be limited to the influence exerted by a single provider's practice. The impact will be significant in a town of only 5-6 providers.

Project Investment: (3) Investment will be reasonable, largely defined by the provider's time and educational materials provided.

094129602.3.1	*3.IT-1.7*	**Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)**	
Moore County Hospital District (Memorial Hospital)			**094129602**
Related Category 1 or 2 Projects:	***094129602.1.1***		
Starting Point/Baseline:	***To be developed in DY3***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2] Establish baseline rates **Data Source:** E.H.R **Process Milestone 1 Estimated Incentive Payment*:*** $23,676	**Process Milestone 2 [P-2]** Establish baseline rates **Data Source:** E.H.R. **Process Milestone 2 Estimated Incentive Payment:** $27,443	**Outcome Improvement Target 1** [IT-1.7]: Controlling high blood pressure **Improvement Target:** Improvement over prior year **Data Source:** E.H.R. **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $44,036	**Outcome Improvement Target 2** [IT-1.7]: Controlling high blood pressure **Improvement Target:** Improvement over prior year **Data Source:** E.H.R **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $105,304
Year 2 Estimated Outcome Amount: $23,676	**Year 3 Estimated Outcome Amount:** $27,443	**Year 4 Estimated Outcome Amount:** $44,036	**Year 5 Estimated Outcome Amount:** $105,304
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $200,459			

Outcome Measure Title: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Performing Provider: Moore County Hospital District (Memorial Hospital)/094129602
RHP Outcome Identification Number: **094129602.3.3 – "PASS 3b"**
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

The purpose of this outcome measure is to increase patient satisfaction scores from a baseline in regards to "how well doctors communicate". Moore County Hospital District will seek to achieve a 5 percent overall improvement using the HCAHPS survey administered by HealthStream for this question. This project correlates with Moore County Hospital District's Category 1 project to **expand specialty care services** to the community by increasing access to hospitalist services.

For DY2-3, Process Measure P-2 will be required to Establish Baseline Rates. Then in DY4-5, IT-6.1 will be measured and reported. For this measure, the numerator will be the percent improvement in the targeted patient satisfaction domain ("how well doctors communicate"). The denominator will be the number of patients who were administered the survey. The data source will be the HealthStream HCAHPS Survey question "how well doctors communicate". The goal will be to improve overall satisfaction year over year up to 5 percent total.

Rationale:

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspectives on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

DY2-3 Process Milestones were chosen to allow the development of baseline reports. Once those baselines are established, DY4 will seek to improve measured satisfaction over the baseline years. Likewise, in DY5, the goal will be to achieve at least a 5% improvement over the baseline years.

Project Valuation: Our region used a project scoring system based on the following criteria:

Achieves Waiver Goals: (4) Achieving the Triple Aim demands high-quality care, designed to meet the needs of patients, in ways that are cost efficient. Studies have shown that patients' perceptions of care are correlated with compliance and outcomes. Clearly, the communication that exists or does not exist between a patient and the physician is critical to a patient's understanding of the care being received and the plan for achieving an optimal outcome.

Addresses Community Needs: (4) Ensuring and improving communication between a patient and his/her physician should always be a priority.

Project Scope/Size: (3) The size and scope of this project will be limited to the influence exerted by hospitalists working at Moore County Hospital District.

Project Investment: (3) Investment will be modest focused primarily on training and communicating results with physicians. A financial incentive for improved physician performance is likely.

094129602.3.3 – "PASS 3b"	***3.IT-6.1***	***Percent Improvement over baseline of patient satisfaction scores***	
Memorial Hospital – Moore County Hospital District			***094129602***
Related Category 1 or 2 Projects:	***094129602.1.3***		
Starting Point/Baseline:	***Baseline TBD during DY3***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 –P-2 Establish Baseline rates **Data Source:** Patient survey **Process Milestone 1 Estimated Incentive Payment:** $26,248	**Process Milestone 2 – P-2** Establish Baseline rates **Data Source:** Patient Survey **Process Milestone 2 Estimated Incentive Payment:** $ 29,125	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores **Improvement Target:** Improvement over prior year **Data Source:** Patient Survey **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 44,476	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores **Improvement Target:** Improvement over prior year or at least 5% improvement from baseline year **Data Source:** Patient Survey **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 102,252
Year 2 Estimated Outcome Amount: $26,248	**Year 3 Estimated Outcome Amount:** $29,125	**Year 4 Estimated Outcome Amount:** $44,476	**Year 5 Estimated Outcome Amount:** $102,252
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $202,101			

Outcome Measure Title: IT-10.1- Quality of Life
Performing Provider Name/TPI: Muleshoe Area Medical Center/130877708
Unique RHP Outcome Identification number: 130877708.3.1
Outcome Domain: OD-10 Quality of Life/ Functional Status

Outcome Measure Description:

IT-10.1 Quality of Life

- Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population

- Rate 1
  - Numerator: Number of individual SF-36 Surveys showing improved quality of life score.
  - Denominator: Baseline

This project is designed to assess the outcome of 130877708.2.6.2 using Survey SF-36 to measure the level of perceived quality of life improvement for the participants of the Community Wellness Program. Obesity and the associated diseases can quickly erode one's sense of well-being. However, having a plan and the tools to becoming proactive in regard to one's health leads to an increased feeling of being in control, which improves quality of life.

Because the quality of one's life is a subjective measure to be determined by the individual, SF-36 measures the physical and the mental aspects of one's perception. Each individual survey will be scored and used in the calculation. This should give us the best, most accurate information from which to determine the success of our project. The target population (adults 18 and over with BMI 25 – 35) who participate in the 130877708.2.6.2 project will be surveyed for baseline in DY2 and for improvement quotient in DY4 & DY5.

Process Milestones:

- DY2:
  - P-1 Establish Baseline
- DY3:
  - P-2 Conduct Plan-Do-Study-Act cycle

Outcome Improvement Targets for each year:

- DY4
  - IT-10.1 - 10% improvement of individual SF-36 scores for participants with BMI 25-35 over baseline

        - Numerator: Number of individual SF-36 Surveys showing improved quality of life score.
- DY5
    - IT-10.1 - 15% improvement of individual SF-36 scores for participants with BMI 25-35 over baseline
        - Numerator: Number of individual SF-36 Surveys showing improved quality of life score.

Rationale:

Quality of life (IT-10.1) is an element that impacts everyone. Perception of quality of life will influence one's actions and reactions. A low-income individual may feel that the factors that affect the quality of his/her life are mostly beyond his/her control. A sense of helplessness and sometimes hopelessness may result in little effort made to change what can be controlled. By introducing a program that educates, enables one to develop self-control, and rewards positive behaviors, the target population can find ways to be more proactive in regard to many areas of life, especially as it relates to disease prevention or control and maintenance.

The American Psychological Association, Dec 2011, draws a significant link from physical activity and mood boost, alleviation of anxiety and depression, and even the ability to avoid disease. Because mind and body are so linked, it is impossible to improve one without improving the other. A recent study in the Journal of Sports and Exercise states that undergraduate students reported an improved mood connected to physical activity. The CDC states, "Participation in health promotion activities. . .allows individuals to develop knowledge, self-management and coping skills as well as build a social support network. . .these skills can facilitate adopting healthy behaviors in the short-term and lead to changes in the physical, mental, and/or emotional health in the long-term". Low-income patients are less likely to join a gym, hire a personal trainer, or seek out a weight-loss program because of the associated cost. However, if a program is provided at low or no cost to the community, these same patients may choose to participate.

Improvement in quality of life may take on many characteristics and will vary from person to person. The survey to be used to measure the improvement in Quality of Life is SF-36. This survey most directly relates to the areas of improvement in one's perception of well-being that are being addressed in this project.

Process milestones- P-1 and P-2 were chosen due to the lack of accurate reports and resources currently available to measure to identify individuals with BMI between 25 and 35.

Improvement targets were chosen for Rate 1 based on research of outcomes of similar programs established within the workplace setting. Participation from outside the workplace setting has no established measure. These outcome measures are largely affected by social determinants including cultural and behavioral issues, childcare issues, and transportation.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	While this project does not necessarily directly address the health care infrastructure or the quality of the care delivery system, it does however address the issue of improving outcomes while containing cost growth. Bailey County has been determined to be a low-income county, with overlap in the demographic area; participants will be educated in the area of overall health and well-being, increasing the perception of a better quality of life, which is a big step in preventing chronic disease issues that could affect the target population if left unchecked.	**3**
Addresses Community Need(s)	According to the RHP 12 Community Needs Assessment, obesity is of great concern to the medical community. Related diseases are also a constant, growing concern. Voluntary participation in a wellness program will bring about an elevated sense of well-being and an increased feeling of control of one's future. Improving health before a patient develops a chronic disease related to obesity provides the opportunity not only to preserve the good health of the patient, but also to lower the need for medical attention and, therefore, lower costs to the patient and/or the hospital district. Since the cost of chronic care to a low-income patient is often transferred to a larger regional hospital, this project may also have an extended impact to other medical facilities throughout the region and/or state. Outcome Improvement Target 1 – Rate 1 calculation Outcome Improvement Target 2– Rate 1 calculation	**5**
Project Scope/Size	The project consists of conducting a quality of life survey of the participants of project 130877708.2.1 along with the organization of data, scoring and processing of the collected data. Size of project is unknown since it is based on voluntary participation. Process Milestone 1-Establish Baseline Process Milestone 2-Conduct Plan-Do-Study-Act cycle	**3**
Project Investment	The outcome of the overall Community Wellness Project will not demand as many personnel hours as the implementation of the project itself. One full-time employee will be adequate to handle the demands of both the Category 2 and Category 3 sections of this project. There will be some minor expense involved with the printing and distribution of materials as well as postage. Funding for this project is estimated at 6,000. It is to be funded by MAMC in full.	**2**

130877708.3.1	3.IT-10.1	Quality of Life	
Muleshoe Area Medical Center		130877708	
Related Category 1 or 2 Project(s):		130877708.2.1	
Starting Point/Baseline:	Baseline TBD DY 2		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Establish baseline rates **Data Source:** SF-36 assessment tool **Estimated Milestone 1 Incentive Payment:** $ **11,426**	**Process Milestone 2: P-4 Conduct Plan Do Study Act cycles to improve data collection and intervention activities** **Data Source:** Documentation of PDSA cycles and analysis **Estimated Milestone 2 Incentive Payment**:$ 13,244	**Outcome Improvement Target 1: [IT-10.1]: Quality of Life** **Improvement Target:** 10% over baseline improvement of individual quality of life scores for target population **Data Source:** SF-36 **Estimated Outcome Improvement Target 2 Incentive Payment:$** 21,252	**Outcome Improvement Target 2: [IT-10.1]: Quality of Life** **Improvement Target:** 15% over baseline improvement of individual quality of life scores for target population (CN.4) **Data Source:** SF-36 **Estimated Outcome Improvement Target 3 Incentive Payment:** $ 50,818
DY 2 Estimated Outcome Amount: *$ 11,426*	***DY 3 Estimated Outcome Amount:*** *$*	***DY 4 Estimated Outcome Amount:*** *$ 21,252*	***DY 5 Estimated Outcome Amount:*** *$* 50,818
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $96,740			

Outcome Measure Title: IT-6.1 Patient Satisfaction
Performing Provider: Muleshoe Area Medical Center/130877708
Unique RHP Outcome Identification number(s): 130877708.3.2
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description: The outcome measure for Category 3, IT-6.1 is the percentage of improvement over baseline for patient satisfaction scores.

- Process Milestones
  - DY2 -[P-2]: Establish baseline rates.
- Outcome Improvement Targets
  - DY3 -[IT-6.1]: Improvement target is to improve patient satisfaction scores for timely care, appointments, information by 1% over baseline.
  - DY4 -[IT-6.1]: Improvement target is to improve patient satisfaction scores for timely care, appointments, information by 3% over baseline.
  - DY5 -[IT-6.1]: Improvement target is to improve patient satisfaction scores for timely care, appointments, information by 5% over baseline.

Rationale:
Process milestones – Patient satisfaction is an area in which we believe there is always room for improvement. As we strive to provide the very best possible care for the patients in our district, we need their input to determine if we are meeting our objectives or are we missing the mark in one or more areas. In DY2 we will utilize the Rand PSQ-III survey forms and methodology to collect information from 250 randomly selected patients. The scores will then be tabulated and scored. A collective score will be determine and established as the baseline. This information will in turn be used to determine areas of deficit which need to be corrected and/or improved.
Improvement targets- In DY3, DY4, and DY5 we will again collect information from 250 randomly selected patients using the same survey and methodology. As we assess the survey scores in progressive years, we will be able to improve our existing processes in the new and existing clinics as well as integrate the addition of a PCP contracted with the Category 1 project over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient. Currently, there is no method or process in place to measure patient satisfaction within the clinics.

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	The Waiver goals for this project are to improve patient satisfaction through the integration of adding one additional clinic/practice over the course of the waiver period into our existing organization. With this integration and successful identification of patient satisfaction our organization will be able to more directly and accurately address patients concerns in relation to the satisfaction of their care thus increasing the value for the patient as well as making primary care more readily available.	**3**
Addresses Community Need(s)	According to the Regional Health Partnership Region 12 Rural Needs Assessment the population of rural counties will increase steadily from 397,997 in 2010 to 451.577 in 2040. The need for an additional PCP will only be exacerbated over the coming years with additional increase in projected population. Also, according to the Needs Assessment for Region 12, the poverty level is higher (19.2% to 15.4%) for the region compared to the state overall. The educational level attained as well as the income levels for individuals located in Region 12 is lower than that of their state counterparts. The lower socioeconomic levels of many Bailey County residents puts them at a far greater risk for health and wellness issues relating to diet and nutrition, as well as childhood health issues such as immunizations and healthy physical development. An addition of a PCP will directly impact the accessibility of lower socioeconomic patients to basic healthcare.	**5**

Project Scope/Size	This Category 3 project in improving patient satisfaction will be a reflection of the benefit to be realized with primary care expansion (Category 1 Project). The targeted population will not only realize the benefits to increasing access to health care, but also receiving the most value for their healthcare dollar. The targeted population will be the residents of Bailey County. The sampling of 250 patients may seem small in comparison to the population of the District. However, the sampling should be representative of the patient base as a whole.	**5**
Project Investment	Relative to our other proposed projects the expected investment will be relatively small. This project is selected to determine a method of tracking customer service for the patients served by MAMC and improving on our patient satisfaction. The additional investment with this Category 3 project will be to determine with the same sample method for obtaining quality patient satisfaction information using the same process or procedure as the primary care process/procedure. The financial investment in this project is small due to the fact that it will be conducted by existing personnel and manually tabulated.	**2**

13087708.3.2	***3.IT-6.1***	***Patient Satisfaction Scores***	
Muleshoe Area Medical Center		***130877708***	
Related Category 1 or 2 Project(s):	***13087708.1.1***	Establish additional Primary Care Clinic and Recruit Primary Care	
Starting Point/Baseline:	***Baseline TBD DY 2***		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1 [P-2]: *Establish baseline rates.* **Data Source:** *Report compilation of PSQ-III Survey Scores (250 completed patient surveys)* **Process Milestone 1 Estimated Incentive Payment:** $ 4,684	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement of baseline patient satisfaction scores **Improvement Target:** *Improvement over baseline established in DY2 of 1% for each (1) getting timely care, (2) appointments, and (3) information.* **Data Source:** *Report compilation of PSQ-III Survey Scores (250 completed patient surveys)* **Outcome Improvement Target 1 Estimated Incentive Payment*: 5,430***	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement of baseline patient satisfaction scores **Improvement Target:** *Improvement over baseline established in DY3 of 3% for each (1) getting timely care, (2) appointments, and (3) information.* **Data Source:** *Report compilation of PSQ-III Survey Scores (250 completed patient surveys)* **Outcome Improvement Target 2 Estimated Incentive Payment*: 8,713***	**Outcome Improvement Target 3** [IT-6.1]: Percent Improvement of baseline patient satisfaction scores **Improvement Target:** *Improvement over baseline established in DY3 of 5% for each (1) getting timely care, (2) appointments, and (3) information.* **Data Source:** *Report compilation of PSQ-III Survey Scores (250 completed patient surveys)* **Outcome Improvement Target 3 Estimated Incentive Payment*: 20,835***
DY 2 Estimated Outcome Amount: $ 4,684	*DY 3 Estimated Outcome Amount: $ 5,430*	*DY 4 Estimated Outcome Amount: $ 8,713*	*DY 5 Estimated Outcome Amount: $ 20,835*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $39,662			

Outcome Measure Title: IT-6.1- Percent improvement over baseline of patient satisfaction scores.
RHP Performing Provider/ TPI: Ochiltree Hospital District / 112704504
Unique RHP outcome identification number(s): 112704504.3.1
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

IT-6.1 - Percent improvement over baseline of patient satisfaction scores.

1. How well their doctors communicate.
    a. Numerator: Percent improvement in targeted patient satisfaction domain
    b. Data Source: Patient survey (CG-CAPHS)
    c. Denominator: Number of patients who were administered the survey

Process Milestones:

- DY2
    - P-3 – Develop and test data plan to track patient satisfaction with primary care services.

- DY3
    - P-3 – Develop and test data plan to track patient satisfaction with primary care services.
    - P-2 – Establish Baseline Rates

Outcome Improvement Target(s) for each year:

- DY4:
    - IT- 6.1 – 3% Improvement in patient satisfaction scores.

- DY5:
    - IT- 6.1 – 5% Improvement in patient satisfaction scores.

Rationale:

DY 2 Process Milestones were chosen due to lack of accurate reports, access to information, and our current infrastructure isn't sufficient to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, project planning milestones and establishing baseline rates must be accomplished in DY2 and DY3.

Due to lack of baseline data Improvement Target levels are TBD until process milestones in DY2 and DY3 have been completed.

Related Category 1 Project:

112704504.1.1 - Expand Primary Care Capacity
Project Option: 1.1.2 – Expand existing primary care capacity
Project Components: a) Expand primary care clinic space,
b) Expand primary care clinic hours,
c) Expand primary care clinic staffing.

Outcome Measure Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	Patients get frustrated by a lack of access or communication in American healthcare delivery. Systems are fractured and patients fall through the cracks. Declining patient satisfaction scores signal a problem with both the quality and cost of care. By designing care systems from a patient point of view, we better serve them. And by proactively seeking to meet patient needs, our hospital's satisfaction scores should improve.	5
Addresses Community Need(s)	Patient satisfaction scores are an indicator of how well a hospital is meeting overall community need. Even when there is slight variance among survey questions, an overall rating gives insight into community perception of its local hospital.	4
Project Scope/Size	This project will entail: • Informing patients of the extended hours and added staff , which should lead to increased timeliness in accessing appointments, care, and information locally, thereby increasing patient satisfaction • Requesting that patients fill out the patient satisfaction survey and explaining the justification for the survey	3

	• Training clinic staff to administer the survey	
Project Investment	This project will require: • Human resources – training • Equipment purchase and maintenance – survey instrument • Time to implement – two years	4

112704504.3.1	3.IT-6.1	Percent Improvement over Baseline of Patient Satisfaction Scores	
Ochiltree Hospital District			112704504
Related Category 1 or 2 Projects:	112704504.1.1		
Starting Point/Baseline:	Improvement targets will be determined in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3]: Develop and test data plan to track patient satisfaction on how well their doctors communicate. **Data Source:** documentation of tested system **Process Milestone 1 Estimated Incentive Payment:** $ 24,423	**Process Milestone 2 [P-3]:** Develop and test data plan to track patient satisfaction on how well their doctors communicate. **Data Source:** documentation of tested and selected system **Process Milestone 2 Estimated Incentive Payment:** $14,155 **Process Milestone 3 [P-2]:** Establish Baseline Rates **Data Source:** CG-CAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population **Process Milestone 3 Estimated Incentive Payment:** $14,155	**Outcome Improvement Target 1 IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores** **Improvement Target:** 3% Improvement in patient satisfaction scores on how well their doctors communicate from baseline **Data Source:** CG-CAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population selected in DY2-3 **Outcome Improvement Target 1 Estimated Incentive Payment:** $45,428	**Outcome Improvement Target 2 IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores** **Improvement Target:** 5% Improvement in patient satisfaction scores on how well their doctors communicate from baseline **Data Source:** CG-CAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population selected in DY2-3 **Outcome Improvement Target 2 Estimated Incentive Payment:** $108,633
Year 2 Estimated Outcome Amount: $24,423	Year 3 Estimated Outcome Amount: $28,310	Year 4 Estimated Outcome Amount: $45,428	Year 5 Estimated Outcome Amount: $108,633
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $206,794			

Outcome Measure Title: IT-6.1- Percent improvement over baseline of patient satisfaction scores.
Performing Provider/ TPI: Ochiltree Hospital District / 112704504
Unique RHP outcome identification number(s): 112704504.3.2 – **"PASS 2"**
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

IT-6.1 - Percent improvement over baseline of patient satisfaction scores.

1. How well their doctors communicate.
    a. Numerator: Percent improvement in targeted patient satisfaction domain
    b. Data Source: Patient survey
    c. Denominator: Number of patients who were administered the survey

Process Milestones:

- DY2
    - P-3 – Develop and test data plan to track patient satisfaction with primary care services.
- DY3
    - P-3 – Develop and test data plan to track patient satisfaction with primary care services.

Outcome Improvement Target(s) for each year:

- DY4:
    - IT- 6.1 – Improve patient satisfaction scores 3% over baseline.
- DY5:
    - IT- 6.1 – Improve patient satisfaction scores 5% over baseline.

Rationale:

DY 2 Process Milestones were chosen due to lack of accurate reports, access to information, and our current infrastructure isn't sufficient to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, project planning milestones and establishing baseline rates must be accomplished in DY2 and DY3.

Due to lack of baseline data Improvement Target levels are TBD until process milestones in DY2 and DY3 have been completed.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	**Patients get frustrated by a lack of access or communication in American healthcare delivery. Systems are fractured and patients fall through the cracks.** **Declining patient satisfaction scores signal a problem with both the quality and cost of care.** **By designing care systems from a patient point of view, we better serve them. And by proactively seeking to meet patient needs, our hospital's satisfaction scores should improve.**	**5**
Addresses Community Need(s)	**Patient satisfaction scores are an indicator of how well a hospital is meeting overall community need. Even when there is slight variance among survey questions, an overall rating gives insight into community perception of its local hospital.**	**4**
Project Scope/Size	**This project will entail:** • **Requesting that patients fill out the patient satisfaction survey and explaining the justification for the survey** • **Training clinic staff to administer the survey**	**3**
Project Investment	**This project will require:** • **Human resources – training** • **Equipment purchase and maintenance – survey instrument** • **Time to implement – two years**	**4**

112704504.3.2 – "PASS 2"	3.IT-6.1	Percent Improvement over baseline of Patient Satisfaction scores	
Ochiltree General Hospital/Ochiltree Hospital District			112705404
Related Category 1 or 2 Projects:	112704504.2.1		
Starting Point/Baseline:	baseline will be determined in DY 2 for implementation in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3]: Develop and test data plan to track patient satisfaction on how well their doctors communicate. **Data Source:** documentation of tested system **Process Milestone 1 Estimated Incentive Payment:** $ 3,737	**Process Milestone 2** [P-3]: Develop and test data plan to track patient satisfaction on how well their doctors communicate. **Data Source:** documentation of tested system **Process Milestone 2 Estimated Incentive Payment:** $2,073 **Process Milestone 3 [P-2]:** Establish Baseline Rates **Data Source:** HCAPHS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population **Process Milestone 3 Estimated Incentive Payment:** $2,073	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of Patient Satisfaction Scores **Improvement Target:** 3% over baseline Improvement in patient satisfaction scores on how well their doctors communicate. **Data Source:** HCAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population selected in DY2-3. **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $6,332	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of Patient Satisfaction Scores **Improvement Target:** 5% over baseline Improvement in patient satisfaction scores on how well their doctors communicate. **Data Source:** HCAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population selected in DY2-3. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $14,557
Year 2 Estimated Outcome Amount: $3,737	**Year 3 Estimated Outcome Amount:** $4,146	**Year 4 Estimated Outcome Amount:** $6,332	**Year 5 Estimated Outcome Amount:** $14,557
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $28,772			

Outcome Measure Title: IT-1.7 Controlling High Blood Pressure
Performing Provider: Pampa Regional Medical Center (PRMC)/178848102
Unique RHP Outcome ID: 178848102.3.1
Outcome Domain: OD-1 Primary Care and Chronic Disease Management

Outcome Measure Description:

IT-1.7 Controlling High Blood Pressure:

- The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year

The purpose of this outcome measure is to demonstrate an ability to decrease blood pressure of hypertensive patients within the practice of a newly recruited provider. This project correlates with Pampa Regional Medical Center's District's Category 1 project to recruit a new primary care provider to its community.

Process Milestones:

- **DY2-3**
  - **Process Measure P-2** will be required to Establish Baseline Rates.

Outcome Improvement Targets for each year:

- **DY4-5**
  - **IT-1.7** Controlling High Blood Pressure will be measured and reported.
    - For this measure, the numerator will be the number of patients in the denominator whose most recent blood pressure is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator will be patients in the practice/clinic ages 18 to 85 as of December 31 of the measurement year with a diagnoses of hypertension. The data source will be the EHR for the practice/clinic. The goal will be to improve compliance from the previous year.

Rationale:

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. In Texas, the rate is slightly less at 27.8 percent of the population, according to DSHS. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke, and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mmto 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 to 20 percent reduction in mortality from coronary heart disease. Literature from clinical trials indicates that 53 to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and Joint National Committee.

The process milestones were chosen for project to establish a baseline rates by obtaining data from EHR. The improvement achievement targets will be determined after the baseline has been identified.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Achieves Waiver Goals: (5) Achieving the Triple Aim demands high-quality care, designed to meet the needs of patients, in ways that are cost efficient. As previously established, unmanaged hypertension has a deleterious long-term effect on health. As health deteriorates, costs rise. Thus, a focused effort to control hypertension within a patient population will naturally produce immediate health benefits for the patient and long-term benefits for healthcare costs. In 2011, Average Household Income in Gray County was $52,171. Gray County falls well below the State Average Household Income of $65,413 and the US Average Household Income of $67,529. Therefore, many of the patients who will necessarily be treated as a part of a PMG-employed provider's practice will be low-income, including Medicaid.

Addresses Community Needs: (5) If between 27.8 and 33.5 percent of Gray County residents have hypertension, as studies suggest, this disease process is clearly a pressing community need that should be managed.

Project Scope/Size: (3) The size and scope of this project will be limited to the influence exerted by a single provider's practice. The impact will be significant in a town of only 8-10 providers.

Project Investment: (3) Investment will be reasonable, largely defined by the provider's time and educational materials provide.

178848102.3.1	3.IT-1.7	Controlling High Blood Pressure	
Pampa Regional Medical Center			178848102
Related Category 1 or 2 Projects::	178848102.1.1		
Starting Point/Baseline:	To be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2] Establish baseline rates **Data Source:** E.H.R. **Process Milestone 1 Estimated Incentive Payment***:* $ 86,588	**Process Milestone 2 [P-2]** Establish baseline rates **Data Source:** E.H.R. **Process Milestone 3 Estimated Incentive Payment:** $ 100,366	**Outcome Improvement Target 1** [IT-1.7]: Controlling High blood pressure **Improvement Target:** Improve over prior year at least 10% of existing patients and 20% of new patients. The percentages will be calculated from Year 3 patient data. **Data Source:** E.H.R. **Outcome Improvement Target 1 Estimated Incentive Payment***:* $161,053	**Outcome Improvement Target 2** [IT-1.7]:Controlling High blood pressure **Improvement Target**: Improve over prior year **Data Source:** E.H.R. **Outcome Improvement Target 2 Estimated Incentive Payment***:* $ 385,126
Year 2 Estimated Outcome Amount: $86,588	**Year 3 Estimated Outcome Amount:** $100,366	**Year 4 Estimated Outcome Amount:** $161,053	**Year 5 Estimated Outcome Amount:** $ 385,126
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $733,133			

Title of Outcome Measure: IT-2.1 Congestive Heart Failure Admission rate (CHF)
Performing Provider: Parmer Medical Center /137343308
Unique RHP outcome identification number: 137343308.3.1

Outcome Measure Description:

IT-2.1 – Congestive Heart Failure Admission Rate (CHF)-

- Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF

Process Milestones:

- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY3:**
  - P-1– Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and documents implementation plans

Outcome Improvement Target(s) for each year*:*

- ***DY4:***
  - **IT-2.1** Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline.
- ***DY5:***
  - **IT - 2.1** -Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline.

RATIONALE

Process milestone – P1 was chosen so we can review chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. The Chronic Care Model has helped hundreds of providers improve care for people with chronic conditions. Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or

self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients.91 Also, an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained one or more chronic Care Model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).92

Improvement Target IT- 2.1 Congestive Heart Failure Admission rate (CHF) was chosen based on data from Texas Department of State Health Services Report. CHF was the top admitting diagnosis for Parmer Medical Center. These outcome measures being addressed are affected by social determinants other than by this projects CHF admission rate also, for instance, lifestyle issues, transportation issues, cultural competency training, noncompliance patients, etc.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. The chronic care management model (CCMM) addresses the healthcare needs of all patients regardless of their financial resources. By implementing the CCM Model, we should be able to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. CCM Model involves a multidisciplinary team to help foster a healthier lifestyle, compliance with medications and treatment plans, and offers support for those patients diagnosed with a chronic disease. The team will coordinate care, ensure follow-up with patients and providers and offer education to the community as a whole.	**5**
Addresses Community Need(s)	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. RHP 12 has identified Expanding Chronic Care Management as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN3- Poor insurance support or uninsured. CN4- High incidence of obesity, diabetes mellitus and heart disease CN10- High prevalence of asthma and care issues RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.3 and CN.4 have been defined as *Urgent Needs*, and CN.10 falls in the category of *Important Need But Less Urgent.*	**5**

	The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.3	
Project Scope/Size	From 2005 - 2010, 92 adult residents of Parmer Medical Center were hospitalized with a chronic disease resulting in Parmer Medical Center receiving $2,532,586 in charges ($27,831 average charge) for those hospitalizations that were potentially preventable if the residents had increased access to care, had cooperated with appropriate healthcare, and had a multi-disciplinary support team to assist in monitoring and managing the chronic disease. We would implement a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project.	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Chronic Care Model, so our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all members of our multi-disciplinary staff and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**4**

137343308. 3.1	3.IT-2.1	Congestive Heart Failure Admission rate (CHF)	
Parmer Medical Center		**137343308**	
Related Category 1 or 2 Projects:	**137343308.2.1**		
Starting Point/Baseline:	**To be determined**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Milestone 1: P-1 Project Planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plans **Data Source:** Program materials **Process Milestone 1 Estimated Incentive Payment:** $ 10,412	***Milestone 2:* P-1** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plan **Data Source:** HR, Training Program materials **Estimated Milestone 2 Incentive Payment:** *$12,069*	**Outcome Improvement Target 1: IT-2.1 Congestive Heart Failure Admission rate (CHF)** **Improvement Target:** Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline. **Data Source:** EHR, Claims **Estimated Outcome Improvement Target 1 Incentive Payment:$19**,367	**Outcome Improvement Target 2: IT-2.1 Congestive Heart Failure Admission rate (CHF)** **Improvement Target:** Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline. **Data Source:** EHR, Claims **Estimated Outcome Improvement Target 1 Incentive Payment:$46**,313
DY 2 Estimated Outcome Amount: *$10,412*	***DY 3 Estimated Outcome Amount:*** *$12,069*	***DY 4 Estimated Outcome Amount****:* *$19,367*	***DY 5 Estimated Outcome Amount:*** *$46,313*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*: $88,161*			

Outcome Measure Title: IT-6.1 Percent improvement over baseline of patient satisfaction scores

Performing Provider Name/TPI: Parmer County Community Hospital dba Parmer Medical Center /137343308

Unique RHP outcome identification number: 037343308.3.3 – "PASS 3b"

Outcome Measure Description:

IT-6.1 Percent improvement over baseline patient satisfaction scores has been chosen to document year over year the success of the category 2 project. By the end of the waiver period, the hospital will establish baseline rates and then improve on them by goals to be determined once baselines are established.

Process Milestones:

- **DY2:**
  - P-1 – Project planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**
  - P-2 – Establish baseline rates

Outcome Improvement Target(s) for each year*:*

- **DY4:**
  - IT-6.1- Percent improvement over baseline of patient satisfaction scores by a % TBD
- **DY5:**
  - IT – 6.1- Percent improvement over baseline of patient satisfaction scores by a 5% increase over DY4

RATIONALE

The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven up upward partially by the increase of costly readmissions and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by detailed patient questionnaires detailing the patients' satisfaction or dissatisfaction of the hospital's services.

Metrics and Milestones: Establishing a healthcare program to provide support and satisfaction to our population will enhance the goals of RHP 12. Providing training for all staff will assist in diminishing the deficiencies in the current delivery system encouraging providers, nursing and ancillary staff to provide the best patient experience possible from our facility. When we provide a supportive environment and patients are satisfied with the care that they have received from our doctors, nurses and other health care team then the potential for compliance with the preventive or treatment plan is much more likely. By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient.

Outcome Measure Valuation: As a small rural county, the need for appropriate care in the initial setting is vitally important. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.

Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Redesign to Improve Patient Experience will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will ensure positive outcomes and will enhance patients' abilities to manage their own illnesses. The patient experience and satisfaction model addresses the healthcare needs of all patients regardless of language, ethnicity or cultural beliefs. By implementing the Patient Experience Model, we should be able to improve patient satisfaction and promote a healthier population. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.	**5**
Addresses Community Need(s)	RHP 12 has identified Redesign to Improve Patient Experience as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: • CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care • CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. • CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult. • CN.6- Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.5 and CN.6 have been defined as *Urgent Needs.*	**5**

Project Scope/Size	We would implement a nationally recognized survey that would capture pertinent data using a patient questionnaire detailing the patients' satisfaction or dissatisfaction of the hospital's services. Once obtaining this data the facility will build upon strengths and correct weaknesses revealed by the survey. This project will require education of several key executive staff members along with training of the entire staff.	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a system wide patient experience model, so our investment in a nationally recognized survey, development of program, educating key executive staff and training for all staff members. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**5**

037343308.3.3 – "PASS 3b"	3.IT-6.1	Percent Improvement over Patient Satisfaction	
Parmer County Community Hospital dbs Parmer Medical Center		**137343308**	
Redesign to Improve Patient Experience	**137343308.2.3**		
Starting Point/Baseline:	**Baseline will be established in DY3**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determined timelines and document implementation plans **Data Source:** Documentation of project planning **Process Milestone 1 Estimated Incentive Payment:** $ 7,249	Process Milestone 2: P-2 Establish baseline rates **Data Source:** EHR; claims **Estimated Milestone 2 Incentive Payment:** $8,044	Outcome Improvement Target 1 IT-6.1 Percent improvement over baseline of patient satisfaction scores **Improvement target**: __TBD___% increase in satisfaction scores over baseline **Data Source:** HCAHPS Survey results **Estimated Outcome Improvement Target 1 Incentive Payment:** $12,284	Outcome Improvement Target 2 IT-6.1 Percent improvement over baseline of patient satisfaction scores **Improvement target:** __5___% increase in satisfaction scores over DY4 Data Source: HCAHPS Survey results Estimated Outcome Improvement Target 2 Incentive Payment:$28,241
DY 2 Estimated Outcome Amount: $7,249	**DY 3 Estimated Outcome Amount:** $8,044	**DY 4 Estimated Outcome Amount:** $12,284	**DY 5 Estimated Outcome Amount:** $28,241
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $55,819			

Outcome Measure Title: IT-9.2 - ED Appropriate utilization
Performing Provider: Plains Memorial Hospital/136142011
Unique Outcome ID: 136142011.3.1
Outcome Domain: 9 – Right Care, Right Setting

Outcome Measure Description:
IT-9.2 ED appropriate utilization:

- Reduce all ED visits
  - Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease /Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Process Milestones:

DY2:

- P-1 - Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- P-2 - Establish baseline rates.

DY3:

- P-5 – Disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome Improvement Targets:

DY4:

- IT-9.2: ED appropriate utilization. Enroll targeted population in Patient Navigation Program. DY 4 should be at least 20% enrollment which should decrease inappropriate ED use by 5% above baseline rates.

DY5:

- IT-9.2: ED appropriate utilization. Enroll targeted population in Patient Navigation Program. DY 5 should be at least 30% enrollment which should decrease inappropriate ED use by 10% above baseline rates.

Rationale:

Reasons for selecting Process Milestones:
P-1, P-2 and P-5 Process Milestone were chosen due to lack of exact reports, complete information, accessibility of resources, current infrastructure aren't' adequate to measure and monitor actual cases of ED use to determine a baseline for non-emergent use. In order to report accurate data and establish baselines, P-1 and P-2 milestones must be approached in DY2 and P-5 in DY3.
Improvement Target Achievement levels:
IT-9.2 Improvement Target was chosen to reduce all ED visits with a focus on non-emergent users. PMH must first determine a baseline by enrolling our target population into our Patient Navigation Program, based on the findings we hope to reduce all ED visits overall. These outcome measures will be largely affected by social determinants such as behavioral issues, transportation issues, lack of education of what the ED should be used for, and language barriers.
Related Category 2 Project: 136142011.2.1
Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This program will provide improved healthcare to those most in need. The program will focus on the targeted patients who are at high risk of disconnect from institutionalized health care. The program we propose will not be limited to but will put a large focus on the efforts to reduce overall ED visits. With the CHW on staff we will be able to further develop and maintain a coordination of care throughout the health care delivery system. This will improve outcomes as well as being a cost effective to both the patient and PMH.	**5**
Address Community Needs	The Community Needs Assessment and the U.S. Census Bureau both reflect that Castro County has an abundant population that is very vulnerable because of ethnic, cultural, economic, geographic, and health characteristics. Our residents are in a group that is at risk for not obtaining the necessary medical care, and thus constitutes a potential threat to their health. We average 220 patients per month through the ED. Approximately 70% of these visits are for non- urgent, non-emergent care. They are using the ED to receive primary care services instead of accessing the rural health clinic. With our plan we hope to address many needs, such as transportation, communication, specialty care, child care, follow up appointments and medication. PMH believes facing these challenges will decrease the cost and help to provide the right care in the right setting.	**5**
Project Scope/Size	This is the only project we are proposing in Pass 1. The project will encompass all ED visits even though our primary focus is on those that misuse the ED. PMH will recruit and train a CHW once the project is approved. This person will have to be Spanish speaking or an interpreter available; will have to familiarize him/herself with the ethnic, cultural, geographic, education, economic and healthcare characteristics specific to our county.	**5**
Project Investment	**PROJECT INVESTMENT**: Our overall project investment will be $628,058. This includes our Category 2 investment.	**5**

136142011.3.1	3.IT-9.2	ED APPROPRIATE UTILIZATION	
PLAINS MEMORIAL HOSPITAL		136142011	
Related Category 1 or 2 Project(s):	136142011.2.1		
Starting Point/Baseline	To be determined in DY2		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	
Process Milestone 1: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Community Needs Assessment, ED Logs. **Process Milestone 1 Estimated Incentive Payment:** $6,650.50 **Process Milestone 2: P- 2** Establish baseline rates. **Data Source:** ED logs **Process Milestone 2 Incentive Payment:** $6,650.50	**Process Milestone 3:P- 5** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Reports generated from the ED EMR. **Process Milestone 3 Incentive Payment:** $15,337	**Outcome Improvement Target 1: IT-9.2 ED APPROPRIATE UTILIZATION** **Improvement Target:** ED appropriate utilization. Reduce targeted ED visits in DY 4 by 5% above baseline rates. **Data Source:** Cost of illness Analysis. ED logs. **Estimated Outcome Improvement Target 1 Incentive Payment:** $24,609	**Outcome Improvement Target 2: IT-9.2 ED APPROPRIATE UTILIZATION** **Improvement Target:** ED appropriate utilization. Reduce targeted ED visits in DY 5 by 10% above baseline rates. **Data Source:** Cost of illness Analysis. ED logs. **Estimated Outcome Improvement Target 2 Incentive Payment:** $58,849
DY 2 Estimated Outcome Amount: $13,301	**DY 3 Estimated Outcome Amount:** $15,337	**DY 4 Estimated Outcome Amount:** $24,609	**DY 5 Estimated Outcome Amount:** $58,849
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $112,096			

Title of Outcome Measure: IT-2.1 Congestive Heart Failure Admission rate (CHF)
Performing Provider: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital /126840107
Unique RHP outcome identification number: 126840107.3.1

Outcome Measure Description:

I**T-2.1 – Congestive Heart Failure Admission Rate (CHF)**

- Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF

Process Milestones:

- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY3:**
  - P-1– Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and documents implementation plans

Outcome Improvement Target(s) for each year*:*

- ***DY4:***
  - IT-2.1 Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline

- ***DY5:***
  - IT - 2.1 Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline

RATIONALE

Process milestone – P1 was chosen so we can review chronic care management best practices and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. The Chronic Care Model has helped hundreds of providers improve care for people with chronic conditions. Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or

self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients.91 Also, an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained one or more chronic Care Model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).92

Improvement Target IT- 2.1 Congestive Heart Failure Admission rate (CHF) was chosen based on data from Texas Department of State Health Services Report. CHF was the top admitting diagnosis for Collingsworth General Hospital. These outcome measures being addressed are affected by social determinants other than by this projects CHF admission rate also, for instance, lifestyle issues, transportation issues, cultural competency training, noncompliance patients, etc.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. The chronic care management model (CCMM) addresses the healthcare needs of all patients regardless of their financial resources. By implementing the CCM Model, we should be able to prevent unnecessary ED visits, prevent hospitalizations and promote a healthier population. CCM Model involves a multidisciplinary team to help foster a healthier lifestyle, compliance with medications and treatment plans, and offers support for those patients diagnosed with a chronic disease. The team will coordinate care, ensure follow-up with patients and providers and offer education to the community as a whole.	**5**
Addresses Community Need(s)	Chronic Disease Management will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will initiate active follow-up to ensure positive outcomes, and will enhance patients' abilities to manage their own illnesses. Hospital admissions related to chronic disease will decrease in DY4 and DY5 as individual knowledge of and compliance with the disease process increases. RHP 12 has identified Expanding Chronic Care Management as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN3- Poor insurance support or uninsured. CN4- High incidence of obesity, diabetes mellitus and heart disease CN10- High prevalence of asthma and care issues RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.3 and CN.4 have been defined as *Urgent Needs*, and CN.10 falls in the category of *Important Need But Less Urgent.*	**5**

	The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.3	
Project Scope/Size	From 2005 - 2010, 369 adult residents of Collingsworth County were hospitalized with a chronic disease resulting in Collingsworth County receiving $3,631,688 in charges for those hospitalizations that were potentially preventable if the residents had increased access to care, had cooperated with appropriate healthcare, and had a multi-disciplinary support team to assist in monitoring and managing the chronic disease. We would implement a multi-disciplinary team that may include but not be limited to Providers, Nurses, Dietician, Physical Therapist, Certified Health Coach, Case Manager, Pharmacist and Social Worker trained in the Chronic Care Model as well as invited expert speakers to support these patients navigating through the project.	**4**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a Chronic Care Model, so our investment for this project will involve a large amount of time spent in development, education and training. Currently we do not employ all members of our multi-disciplinary staff and would incur costs of filling these positions. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**4**

126840107.3.1	3.IT-2.1	Congestive Heart Failure Admission rate (CHF)	
Preferred Hospital Leasing, Inc dba Collingsworth General Hospital		126840107	
Related Category 1 or 2 Projects:	126840107.2.1		
Starting Point/Baseline:	To be Determined		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	
Milestone 1: P-1 Project Planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plans **Data Source:** Program materials **Process Milestone 1 Estimated Incentive Payment:** $ 4,018	**Milestone 2: P-1** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plan **Data Source:** HR, Training Program materials **Estimated Milestone 2 Incentive Payment:** $4,659	**Outcome Improvement Target 1: IT-2.1 Congestive Heart Failure Admission rate (CHF)** **Improvement Target:** Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline **Data Source:** EHR, Claims **Estimated Outcome Improvement Target 1 Incentive Payment:$**7,476	**Outcome Improvement Target 2: IT-2.1 Congestive Heart Failure Admission rate (CHF)** **Improvement Target:** Reduce all non-maternal discharges of age 18 years and older with a principal diagnosis code of CHF by a % TBD after establishing our baseline **Data Source:** EHR, Claims **Estimated Outcome Improvement Target 1 Incentive Payment:$**17,877
DY 2 Estimated Outcome Amount: $4,018	**DY 3 Estimated Outcome Amount:** $4,659	**DY 4 Estimated Outcome Amount**: $7,476	**DY 5 Estimated Outcome Amount:** $17,877
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $34,030			

Title of Outcome Measure: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Performing Provider: Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital /126840107
Unique RHP outcome identification number: 126840107.3.3 – "PASS 3b"

Outcome Measure Description:
IT-6.1 Percent improvement over baseline patient satisfaction scores has been chosen to document year over year the success of the category 2 project. By the end of the waiver period, the hospital will establish baseline rates and then improve on them by goals to be determined once baselines are established.

Process Milestones:

- **DY2:**
  - P-1 – Project planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**
  - P-2 – Establish baseline rates

Outcome Improvement Target(s) for each year*:*

- ***DY4:***

  IT-6.1- Percent improvement over baseline of patient satisfaction scores

- ***DY5:***
  - IT – 6.1- Percent improvement over baseline of patient satisfaction scores

RATIONALE

The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven up upward partially by the increase of costly readmissions and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by detailed patient questionnaires detailing the patients' satisfaction or dissatisfaction of the hospital's services.

Metrics and Milestones: Establishing a healthcare program to provide support and satisfaction to our population will enhance the goals of RHP 12. Providing training for all staff will assist in diminishing the deficiencies in the current delivery system encouraging providers, nursing and ancillary staff to provide the best patient experience possible from our facility.

Related Category 1 or 2 Projects: 126840107.2.2
Outcome Measure Valuation: As a small rural county, the need for appropriate care in the initial setting is vitally important. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.

Project Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals	Redesign to Improve Patient Experience will improve the knowledge base of providers as well as of patients, will improve coordination among providers and patients, will ensure positive outcomes and will enhance patients' abilities to manage their own illnesses. The patient experience and satisfaction model addresses the healthcare needs of all patients regardless of language, ethnicity or cultural beliefs. By implementing the Patient Experience Model, we should be able to improve patient satisfaction and promote a healthier population. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.	**5**
Addresses Community Need(s)	RHP 12 has identified Redesign to Improve Patient Experience as a project that meets needs from and directly impacts Community Needs (CN) as defined in the regional Community Needs Assessment. This project will target the following Community Needs: • CN1- Severe primary care provider shortage, wait time, expense, lack of insurance, access to care • CN2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact. • CN.5- Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease. Travel to Urban areas for care is difficult. • CN.6- Need for cancer screening with mammograms, pap smears, colonoscopy, sigmoidoscopy, rectal exam RHP 12 has determined that CN.1 and CN.2 are considered *Critical Needs*, CN.5 and CN.6 have been defined as *Urgent Needs.*	**4**

Project Scope/Size	We would implement a nationally recognized survey that would capture pertinent data using a patient questionnaire detailing the patients' satisfaction or dissatisfaction of the hospital's services. Once obtaining this data the facility will build upon strengths and correct weaknesses revealed by the survey. This project will require education of several key executive staff members along with training of the entire staff.	**5**
Project Investment	We are a small rural hospital with limited resources. Currently our facility does not have a system wide patient experience model, so our investment in a nationally recognized survey, development of program, educating key executive staff and training for all staff members. Additional equipment purchases and maintenance will be determined after establishing our project baseline data.	**5**

126840107.3.3 – "PASS 3b"	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Preferred Hospital Leasing, Inc dba Collingsworth General Hospital		**126840107**	
Redesign to Improve Patient Experience	**126840107.2.3**		
Starting Point/Baseline: 0	**Baseline will be established in DY3**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determined timelines and document implementation plans Data Source: Documentation of project planning Estimated Milestone 1 Incentive Payment: $ 6,271	Process Milestone 2: P-2 Establish baseline rates Data Source: EHR; claims *Estimated Milestone 2 Incentive Payment: $6,959*	*Outcome Improvement Target 1* IT-6.1 Percent improvement over baseline of patient satisfaction scores Improvement target: TBD% increase in satisfaction scores over baseline (once baseline is established) Data Source: HCAHPS Survey results *Estimated Outcome Improvement Target 1 Incentive Payment:$10,626*	Outcome Improvement Target 2 IT-6.1 Percent improvement over baseline of patient satisfaction scores Improvement target: TBD% increase in satisfaction scores over DY4 (once baseline is established) Data Source: HCAHPS Survey results *Estimated Outcome Improvement Target 2 Incentive Payment:$24,431*
DY 2 Estimated Outcome Amount: $6,271	*DY 3 Estimated Outcome Amount: $6,959*	*DY 4 Estimated Outcome Amount: $10,626*	*DY 5 Estimated Outcome Amount: $24,431*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $48,287			

Project Title: IT-1.7 Controlling High Blood Pressure
Performing Provider: Physician Network Services/079877902
Unique RHP Outcome ID: 07987902.3.1 – **"PASS 2"**
Outcome Domain: OD-1 Primary Care and Chronic Disease Management

Outcome Measure Description:
IT-1.7 – Controlling high blood pressure

- Patients will be defined as those that are 18 to 85 years of age as of December 31 of the measurement year that have a patient encounter at either the new clinic at the South Plains Mall or at the new clinic located on Interstate 27. Both populations, as defined in the Category 1.1.1 description have unique challenges.
- The numerator will be the number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm HG) during the measurement year.
- The denominator will be all patients from the population definition with a diagnosis of hypertension.

Process Milestones:

- DY 2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates for both clinics
  - P-3 – Develop and test data systems

Outcome Improvement targets for each year:

- DY4:
  - IT-1.7 – Increase the number of patients whose most recent blood pressure is adequately controlled (BP less than 140/90 mm HG) by a TBD %.
- DY5:
  - IT-1.7 – Increase the number of patients whose most recent blood pressure is adequately controlled (BP less than 140/90 mm HG) by a TBD %.

Rationale:
High blood pressure has been conclusively linked to a number of other medical problems. Problems like blood clots, stroke, and heart attack are much more frequent in people who have high blood pressure. Similarly, kidney problems, liver problems, and a number of hormonal disturbances can contribute to or cause the development of high blood pressure. This project would focus on the controlling of high blood pressure with the hopes that there would be a positive cascading effect on our patients.
Process milestones – P-1 through P-3 were chosen as both populations will come from new clinics. According to RHP12 Needs Assessment, there is a lack of access to care (CN1) and there is a high incidence of diabetes and heart disease (CN4). Approximately 76.4 million people in the United States have high blood pressure. We believe that our population will mimic the national numbers but need to establish a baseline (P-2) to confirm. In order to establish the baseline, we must perform P-1 and P-3 in DY2-DY3. In DY3, we will establish baselines with P-2.
Improvement targets are to be determined. Targets will be chosen for our specific population identified in the numerator based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period. These outcome measures being addressed are largely affected by social determinants other than encounters at these new clinics. For instance, cultural and behavioral issues, transportation issues, and demography trends will affect a patient's desire to seek regular and timely visits at the clinics.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Triple Aim goals are directly impacted by access to primary care. By expanding primary care, we are able to provide the right care at the right time and in the right setting. By focusing on lowering high blood pressure in the primary care setting we can prevent emergency room episodes.	**4**
Addresses Community Need(s)	According to RHP12 Needs Assessment, there is a lack of access to primary care (CN1) and there is a high incidence of diabetes and heart disease (CN4). Through expanding primary care (Cat 1.1) and this Category 3 project we will be able to address this need by designing a program to decrease high blood pressure in at-risk patients.	**4**
Project Scope/Size	We would expect through this process that patient visits at the new clinics would continue to increase each year. Regularly scheduled visits with at-risk patients will keep the acuity low. By practicing healthcare in this manner we can prevent high acuity episodes; hence limiting the number of visits to the ER.	**4**
Project Investment	The blood pressure management will not be a significant investment compared to some projects such as establishing new primary care clinics. We will be able to track statistics through our EHR. Investments will be the healthcare provider's time to consistently manage the patients on a regular basis. Other staffing costs will come from the review and planning team.	**4**

079877902.3.1 – "PASS 2"	3.IT-1.7	Controlling High Blood Pressure	
UMC Physician Network Services		079877902	
Related Category 1 or 2 Project(s):	079877902.1.1		
Starting Point/Baseline:	To be developed in DY3		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY5 (10/1/2015-9/30/2016)*
1.Process Milestone P-3.1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meeting minutes, project projections/timelines **Estimated Milestone 1 Payment:** $ 34,426.65 **2. Process Milestone P-3.3** Develop and test data systems **Data Sources:** EHR and practice management system **Estimated Milestone 2 Payment:** $34,426.65	**3. Process Milestone P-3.3** Develop and test data systems **Data Sources:** EHR and practice management system **Estimated Milestone 3 Payment:** $76,401.26 **4.Process Milestone P-3.2** Establish baseline rates **Numerator:** number of patients 18-85 years of age that hit >140/90mm Hg **Denominator**: all patients from two new clinics **Data Source**: EHR and practice management system **Estimated Milestone 4 Payment:** $76,401.26	**5.Outcome Improvement Target2:[IT-1.7] Controlling High Blood Pressure** **Improvement Target:** Increase the number of patients whose most recent blood pressure is adequately controlled (BP less than 140/90 mm HG) by a TBD %. **Data Source**: EHR and practice management system **Estimated Outcome Improvement payment**: $ 155,556.90	**6.Outcome Improvement Target2:[IT-1.7] Controlling High Blood Pressure** **Improvement Target:** Increase the number of patients whose most recent blood pressure is adequately controlled (BP less than 140/90 mm HG) by a TBD %. **Data Source**: EHR and practice management system **Estimated Outcome Improvement payment**: $ 325,122.44
DY 2 Estimated Outcome Amount: $ 68,853	**DY 3 Estimated Outcome Amount:** $ 152,802.51	**DY 4 Estimated Outcome Amount:** $ 155,556.90	**DY 5 Estimated Outcome Amount:** $ 325,122.44
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 702,335.14			

Outcome Measure Title: IT-9.2 ED Appropriate Utilization
Performing Provider: StarCare Specialty Health System/084897001
Unique RHP Outcome ID: 084897001.3.1
Outcome Domain: OD-9 Right Care, Right Setting

Outcome Measure Description:

IT-9.2 - Emergency Department Appropriate Utilization

- Reduce Emergency Department visits for target conditions:
  - Behavioral Health/Substance Abuse

In order to achieve the goals and desired outcomes of this project, the following Process Milestones and Outcome Improvement Targets were selected:

Process Milestones:

Year DY2:

Category 3 – P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness, and document implementation plans.
Data Source: Implementation plan

Year DY3:

Category 3 – P-2: Establish baseline rates
Data Source: Performing Provider Utilization Data, Emergency Department Data

Outcome Improvement Targets:

Year DY4:

IT – 9.2: Emergency department appropriate utilization
Improvement Target: Reduce psychiatric-related emergency department visits by 10% from Baseline
Data Source: Performing Provider Utilization Data, Emergency Department Data

Year DY5:

IT – 9.2: Emergency department appropriate utilization
Improvement Target: Reduce psychiatric-related emergency department visits by 15% from Baseline
Data Source: Performing Provider Utilization Data, Emergency Department Data

Rationale: The above outcome measure, process milestones and outcome improvement targets were selected because they directly address Region 12 Community Needs Assessment ID# CN2 (Critical Need): *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.*

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure patients receive coordinated, timely and site-appropriate healthcare services. StarCare hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	5
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	• Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. StarCare's PESC directly relates to the Region 12 goals of CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 (Urgent Need) Poor insurance support or uninsured.	5
Project Scope/Size Scale: 1 to 5 5 Greatest	During DY4 and DY5, StarCare will provide at least 420 office-based crisis screenings annually, serve an average of 240 adults in the 48-hour extended observation unit each year and serve an average of 360 adults in the 14-day extended care unit each year. Conceivably, over 600 people could be impacted by this project, with a 10% increase from baseline in utilization of this appropriate crisis alternative in DY4 and 15% in DY5. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	4

Project Investment Scale: 1 to 5 5 Greatest	StarCare's investment in this project will be fairly significant. Staffing will include a Program Director, Psychiatrist, Registered Nurses, Qualified Mental Health Professionals, Human Service Technicians, an Administrative Assistant, etc. (shared with other, similar programs, for the purpose of economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc.	4

084897001.3.1	**3.IT-9.2:**	**ED Appropriate Utilization**	
StarCare Specialty Health System			**084897001**
Related Category 1 Project:	**084897001.1.1**		
Starting Point/Baseline:	**To be determined in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans. **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $141,016	**Process Milestone 2: P-2** Establish baseline rates **Data Source:** PP Utilization Data, ED Utilization Data **Process Milestone 2 Estimated Incentive Payment:** $326,916	**Outcome Improvement Target 1:** **IT – 9.2: ED Appropriate utilization** **Improvement Target:** Reduce Behavioral Health/Substance Abuse ED Visits by 10% from DY3 Baseline **Data Source:** PP Utilization Data, ED Utilization Data **Outcome Improvement Target 1 Estimated Incentive Payment:** $349,720	**Outcome Improvement Target 2:** **IT – 9.2: ED Appropriate utilization** **Improvement Target:** Reduce Behavioral Health/Substance Abuse ED Visits by 15% from DY3 Baseline **Data Source:** PP Utilization Data, ED Utilization Data **Outcome Improvement Target 2 Estimated Incentive Payment:** $760,268
Year 2 Estimated Outcome Amount: $141,016	**Year 3 Estimated Outcome Amount:** $326,916	**Year 4 Estimated Outcome Amount:** $349,720	**Year 5 Estimated Outcome Amount:** $760,268
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,577,920			

Outcome Measure Title: IT-9.2 ED Appropriate Utilization
Performing Provider: StarCare Specialty Health System/084897001
Unique RHP Outcome ID: 084897001.3.2 – **"Pass 2"**
Outcome Domain: OD-9 Right Care, Right Setting

Outcome Measure Description:

IT-9.2 - Emergency Department Appropriate Utilization

- Reduce Emergency Department visits for target conditions:
  - Behavioral Health/Substance Abuse

In order to achieve the goals and desired outcomes of this project, the following Process Milestones and Outcome Improvement Targets were selected:

Process Milestones:

Year DY2:

Category 3 – P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness, and document implementation plans.
Data Source: Implementation plan

Year DY3:

Category 3 – P-2: Establish baseline rates
Data Source: Performing Provider Utilization Data, Emergency Department Data

Outcome Improvement Targets:

Year DY4:

IT – 9.2: Emergency department appropriate utilization

Improvement Target: Reduce adolescent psychiatric-related emergency department visits by 10% from Baseline

Data Source: Performing Provider Utilization Data, Emergency Department Data

Year DY5:

IT – 9.2: Emergency department appropriate utilization

Improvement Target: Reduce adolescent psychiatric-related emergency department visits by 15% from Baseline

Data Source: Performing Provider Utilization Data, Emergency Department Data

Rationale: The above outcome measure, process milestones and outcome improvement targets were selected because they directly address Region 12 Community Needs Assessment ID# CN2 (Critical Need): *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.* 4. Establishment of a Psychiatric Emergency Service Center, adolescent crisis respite unit and integrated primary and behavioral health clinic will allow people access to specialized interventions during psychiatric crises and diagnosis-specific after care services and referrals. These will offer more specialized psychiatric expertise than does a general emergency department.

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure adolescents receive coordinated, timely and site-appropriate healthcare services. StarCare hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	5
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	• Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. StarCare's Adolescent Crisis Respite Program directly relates to the Region 12 goals of CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 (Urgent Need) Poor insurance support or uninsured.	5
Project Scope/Size Scale: 1 to 5 5 Greatest	StarCare plans to serve at least 60 adolescents per year in the Crisis Respite Program. When considering the impact upon each person's care experience, his/her health and the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	4
Project Investment Scale: 1 to 5 5 Greatest	StarCare's investment in this project will be fairly significant. Staffing will include a Program Director, Psychiatrist, Registered Nurses, Qualified Mental Health Professionals, Human Service Technicians, an Administrative Assistant, etc. (shared with other, similar programs, for the purpose of economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc.	4

084897001.3.2	3.IT-9.2:	ED Appropriate Utilization	
StarCare Specialty Health System			**084897001**
Related Category 1 Project:	**084897001.1.2**		
Starting Point/Baseline:	**To be determined in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans. **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $21,869	**Process Milestone 2: P-2** Establish baseline rates **Data Source:** PP Utilization Data, ED Utilization Data **Process Milestone 2 Estimated Incentive Payment:**$48,534	**Outcome Improvement Target 1:** **IT – 9.2: ED Appropriate utilization** **Improvement Target:** Reduce Behavioral Health/Substance Abuse ED Visits by 10% from DY3 Baseline **Data Source:** PP Utilization Data, ED Utilization Data **Outcome Improvement Target 1 Estimated Incentive Payment:** $49,409	**Outcome Improvement Target 2:** **IT – 9.2: ED Appropriate utilization** **Improvement Target:** Reduce Behavioral Health/Substance Abuse ED Visits by 15% from DY3 Baseline **Data Source:** PP Utilization Data, ED Utilization Data **Outcome Improvement Target 2 Estimated Incentive Payment:** $103,267
Year 2 Estimated Outcome Amount: $21,869	**Year 3 Estimated Outcome Amount:** $48,534	**Year 4 Estimated Outcome Amount:** $49,409	**Year 5 Estimated Outcome Amount:** $103,267
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $223,078			

Outcome Measure Title: IT-9.2 ED Appropriate Utilization
Performing Provider: Sunrise Canyon Hospital/136492909
Unique RHP Outcome ID: 136492909.3.1 – **"Pass 2"**
Outcome Domain: OD-9 Right Care, Right Setting

Outcome Measure Description:

IT-9.2 - Emergency Department Appropriate Utilization

- Reduce Emergency Department visits for target conditions:
  - Behavioral Health/Substance Abuse

In order to achieve the goals and desired outcomes of this project, the following Process Milestones and Outcome Improvement Targets were selected:

Process Milestones:

Year DY2:

Category 3 – P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness, and document implementation plans.
Data Source: Implementation plan

Year DY3:

Category 3 – P-2: Establish baseline rates
Data Source: Performing Provider Utilization Data, Emergency Department Data

Outcome Improvement Targets :

Year DY4:

IT – 9.2: Emergency department appropriate utilization
Improvement Target: Reduce psychiatric-related emergency department visits by 10% from Baseline
Data Source: Performing Provider Utilization Data, Emergency Department Data

Year DY5:

IT – 9.2: Emergency department appropriate utilization
Improvement Target: Reduce psychiatric-related emergency department visits by 15% from \
Data Source: Performing Provider Utilization Data, Emergency Department Data

Rationale: The above outcome measure, process milestones and outcome improvement targets were selected because they directly address Region 12 Community Needs Assessment ID# CN2 (Critical Need): *Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact* and ID# CN3 (Urgent Need): *Poor insurance support or uninsured.*

Outcome Measure Valuation:

Criteria	Narrative	Score
Achieves Waiver Goals Scale: 1 to 5 5 Greatest	This project is designed to achieve, to the greatest extent possible, the Texas Healthcare Transformation and Quality Improvement (1115 Waiver) goals of 1. Improved patient care experience; 2. Improved health; and 3. Reduced cost of healthcare, without compromised quality. In order to achieve alignment with this *triple aim,* the primary goal of this project is to ensure adolescents receive coordinated, timely and site-appropriate healthcare services. Sunrise Canyon Hospital hopes to address the healthcare disparity of unequal access for people with low-income. This project will transform healthcare delivery from a disease-focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing healthcare system.	5
Addresses Community Need(s) Scale: 1 to 5 5 Greatest	Commissioned by the Regional Healthcare Partnership (RHP), the West Texas Area Health Education Center conducted an assessment of the healthcare-related needs in Region 12. The goals of Region 12 are to address as many identified community needs as possible, focusing on those identified as "critical" and "urgent," including increased access to care, increased prevention and early detection activities and quality/performance improvement. SRCH's integrated clinic directly relates to the Region 12 goals of CN2 (Critical Need) Lack of mental health services, inability to get an appointment, lack of insurance, need to use emergency rooms for initial contact and CN3 (Urgent Need) Poor insurance support or uninsured.	5
Project Scope/Size Scale: 1 to 5 5 Greatest	During each year, DY4 and DY5, SRCH estimates it will provide at least 600 office visits. SRCH estimates a total of 450 people (225/year) could be impacted by this project, with a 5% decrease from baseline in preventable admissions or readmissions into Criminal Justice System in DY4 and a 10% decrease from baseline in DY5. In addition, SRCH expects a 5% and 10% reduction from baseline in psychiatric-related emergency department visits in DY4 and DY5 respectfully. When considering the impact upon each person's care experience, his/her health and	4

	the reduced cost upon the community's healthcare delivery system, the scope and size of this project will be fairly great. This project will be managed by highly trained staff who specialize in linkage to the *right care in the right setting.*	
Project Investment Scale: 1 to 5 5 Greatest	SRCH's investment in this project will be fairly significant. Staffing will include a Program Director, Psychiatrist, licensed nurses, an Administrative Assistant, etc. (shared with other, similar programs, for the purpose of economies of scale.) Other investments include physical space, furnishings and equipment, computer hardware/software, etc.	4

Sunrise Canyon Hospital			136492909
Related Category 2 Project:	136492909		
Starting Point/Baseline:	**To be determined in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans. **Data Source:** Implementation Plan **Process Milestone 1 Estimated Incentive Payment:** $206,560	**Process Milestone 2: P-2** Establish baseline rates **Data Source:** PP Utilization Data, ED Utilization Data **Process Milestone 2 Estimated Incentive Payment:** $229,204	**Outcome Improvement Target 1:** **IT – 9.2: ED Appropriate utilization** **Improvement Target:** Reduce Behavioral Health/Substance Abuse ED Visits by 10% from DY3 Baseline **Data Source:** PP Utilization Data, ED Utilization Data **Outcome Improvement Target 1 Estimated Incentive Payment:** $350,003	**Outcome Improvement Target 2:** **IT – 9.2: ED Appropriate utilization** **Improvement Target:** Reduce Behavioral Health/Substance Abuse ED Visits by 15% from DY3 Baseline **Data Source:** PP Utilization Data, ED Utilization Data **Outcome Improvement Target 2 Estimated Incentive Payment:** $805,678
Year 2 Estimated Outcome Amount: $206,560	**Year 3 Estimated Outcome Amount:** $229,204	**Year 4 Estimated Outcome Amount:** $350,003	**Year 5 Estimated Outcome Amount:** $805,678
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,591,445			

Outcome Measure Title: IT-10.1 Quality of Life
Performing Provider: Texas Panhandle Centers/127378105
Unique RHP Outcome ID: 127378105.3.1
Outcome Domain: OD-10 Quality Of Life/ Functional Status

Outcome Measure Description:

IT-10.1 Quality of Life

- Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for target population.

OD- 10 Quality Of Life/ Functional Status: This Crisis Respite Project, shaped around critical Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving patient's quality of life, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion. The vast majority of the target population for this program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Process Milestones – *DY2 and DY3:* These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- **DY2-P-1 Project planning -** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3-P-2 Establish baseline rates**

Improvement Target – *DY4 and DY5*

- DY4 and DY5- IT-10.1 Quality of Life (*Standalone measure)*
  p. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population.

Rationale: The reasons for selecting the process milestones and outcome improvement targets that were chosen are:

- DY2- P-1 Project planning: To properly implement this project, many activities will need to occur that involve engaging stakeholders, identifying current capacity and needed resources, determining timelines and putting together implementation plans.

- DY3- P-2 Establish baseline rates during DY3 will allow the project to be implemented more effectively and efficiently.
- DY4&DY5- IT-10.1 Quality of Life (*Standalone measure)*: The Crisis Respite Project, shaped around Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving client's quality of life, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion.
- The Implementation Target for this project will be improvement in quality of life for persons served through this program.. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Related Category 1 Project: 127378105.1.13

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria.

Criteria	Narrative	Score
Achieves Waiver Goals	This project was ranked equally with TPC's other CAT 3 projects. It achieves all of the following waiver goals: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth The project primarily impacts Medicaid and/or uninsured residents. The expected impact is very significant, as it addresses "cracks in the system" that need to be addressed. There strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**3**
Addresses Community Need(s)	This project was ranked equally with TPC's other CAT 3 projects. Unique community need identification numbers the project addresses include: *CN.1- Wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact*; *CN.3- Poor insurance support or uninsured;*	**3**
Project Scope/Size	This project was ranked equally with TPC's other CAT 3 projects. Factors considered included the potential population that will be reached; the number of consumer visits/encounters; the number of individual providers recruited/trained, and the savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**
Project Investment	The expected investment to successfully implement this project and achieve milestones and metrics was ranked equally with TPC's other CAT 3 projects. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**3**

127378105.3.1	3.IT-10.1	Quality of Life	
Texas Panhandle Centers		127378105	
Related Category 1 or 2 Project(s):	127378105.1.1		
Starting Point/Baseline: 0	To be determined during DY3		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Project data **Milestone 1 Estimated Incentive Payment:** *$59,688*	**Process Milestone 1: P-2** Establish Baseline rates **Data Source:** Project data **Milestone 1 Estimated Incentive Payment:** *$138,373*	**Outcome Improvement Target 1** **IT-10.1 Quality of Life** **Improvement Target:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD % **Data source:** Validated assessment tool for quality of life. **Outcome Improvement Target 1 Estimated Incentive Payment:** *$148,027*	**Outcome Improvement Target 2** **IT-10.1 Quality of Life** **Improvement Target:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD % **Data source:** Validated assessment tool for quality of life. **Outcome Improvement Target 2 Estimated Incentive Payment:** *321,799*
DY 2 Estimated Outcome Amount: $59,688	**DY 3 Estimated Outcome Amount:** $138,373	**DY 4 Estimated Outcome Amount:** $148,027	**DY 5 Estimated Outcome Amount:** $321,799
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $667,887			

Outcome Measure Title: IT-10.1 Quality of Life
Performing Provider: Texas Panhandle Centers/127378105
Unique RHP Outcome ID: 127378105.3.2
Outcome Domain: OD-10 Quality Of Life/ Functional Status

Outcome Measure Description:

IT-10.1 Quality of Life

- Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population

OD- 10 Quality Of Life/ Functional Status: This Continuum of Care Program, shaped around critical Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving the quality of life of persons with behavioral health needs, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion. The vast majority of the target population for this program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Process Milestones – *DY2 and DY3:* These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- **DY2-P-1 Project planning -** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3-P-2 Establish baseline rates**

Outcome Improvement Targets – *DY4 and DY5*

- **DY4 and DY5- IT-10.1 Quality of Life**
    q. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population by TBD %

Rationale: The reasons for selecting the process milestones and outcome improvement targets that were chosen are:

- DY2- P-1 Project planning: To properly implement this project, many activities will need to occur that involve engaging stakeholders, identifying current capacity and needed resources, determining timelines and putting together implementation plans.
- DY3- P-2 Establish baseline rates during DY3 will allow the project to be implemented more effectively and efficiently.
- DY4&DY5- IT-10.1 Quality of Life (*Standalone measure)*: The Primary and Behavioral Health Integration Project, shaped around Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving client's quality of life, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion.
- The Implementation Target for this project will be improvement in quality of life for persons served through this program.. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

RELATED CATEGORY 2 PROJECT

Unique CAT 2 Project ID: 127378105.2.13

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria.

Criteria	Narrative	Score
Achieves Waiver Goals	This project was ranked equally with TPC's other CAT 3 projects. It achieves all of the following waiver goals: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth The project primarily impacts Medicaid and/or uninsured residents. The expected impact is very significant, as it addresses "cracks in the system" that need to be addressed. There strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**3**
Addresses Community Need(s)	This project was ranked equally with TPC's other CAT 3 projects. Unique community need identification numbers the project addresses include: *CN.1- Wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact*; *CN.3- Poor insurance support or uninsured; CN.8- Alcohol abuse and binge drinking, substance abuse; and CN.9- Tobacco use*	**3**
Project Scope/Size	This project was ranked equally with TPC's other CAT 3 projects. Factors considered included the potential population that will be reached; the number of consumer visits/encounters; the number of individual providers recruited/trained, and the savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**

Project Investment	The expected investment to successfully implement this project and achieve milestones and metrics was ranked equally with TPC's other CAT 3 projects. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**3**

127378105.3.2	3.IT-10.1	Quality of Life	
Texas Panhandle Centers		127378105	
Related Category 1 or 2 Project(s):	127378105.2.1		
Starting Point/Baseline:	to be determined in DY3		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Project data **Milestone 1 Estimated Incentive Payment:** $59,688	**Process Milestone 2: P-2** Establish Baseline **Data Source:** Project data **Milestone 2 Estimated Incentive Payment:** $138,373	**Outcome Improvement Target 1** **IT-10.1 Quality of Life** **Target Improvement:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD % **Data source:** Validated assessment tool for quality of life. **Outcome Improvement Target 1 Estimated Incentive Payment:** *$148,027*	**Outcome Improvement Target 2** **IT-10.1 Quality of Life** **Target Improvement:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by TBD % **Data source:** Validated assessment tool for quality of life. **Outcome Improvement Target 2 Estimated Incentive Payment:** *321,799*
DY 2 Estimated Outcome Amount: $59,688	**DY 3 Estimated Outcome Amount:** $138,373	**DY 4 Estimated Outcome Amount:** *$148,027*	**DY 5 Estimated Outcome Amount:** *$321,799*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD :$667,887			

Outcome Measure Title: IT-10.1 Quality of Life

Performing Provider: Texas Panhandle Centers/127378105

Unique RHP Outcome ID: 127378105.3.3

Outcome Domain: OD-10 - Quality Of Life/ Functional Status

Outcome Measure Description:

IT-10.1 Quality of Life

- Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for target population.

This Primary and Behavioral Health Integration Project, shaped around the two critical Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving patient's quality of life as related to health, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion. The vast majority of the target population for this program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Process Milestones – *DY2 and DY3:* These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- **DY2-P-1 Project planning -** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3-P-2 Establish baseline rates**

Improvement Target – *DY4 and DY5*

- **DY4 and DY5- IT-10.1 Quality of Life (*Standalone measure)***
  r. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population by TBD %

Rationale: The reasons for selecting the process milestones and outcome improvement targets that were chosen are:

- DY2- P-1 Project planning: To properly implement this project, many activities will need to occur that involve engaging stakeholders, identifying current capacity and needed resources, determining timelines and putting together implementation plans.
- DY3- P-2 Establish baseline rates during DY3 will allow the project to be implemented more effectively and efficiently.
- DY4&DY5- IT-10.1 Quality of Life (*Standalone measure)*: The Primary and Behavioral Health Integration Project, shaped around the two critical Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving patient's quality of life as related to health, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion.
- The Implementation Target for this project will be improvement in quality of life for persons served through this program. Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Related Category 1 Project: 127378105.2.15

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project was ranked equally with TPC's other CAT 3 projects. It achieves all of the following waiver goals: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth The project primarily impacts Medicaid and/or uninsured residents. The expected impact is very significant, as it addresses "cracks in the system" that need to be addressed. There strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**3**
Addresses Community Need(s)	This project was ranked equally with TPC's other CAT 3 projects. Unique community need identification numbers the project addresses include: *CN.1- Severe primary care provider shortage Wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact*; *CN.3- Poor insurance support or uninsured;*	**3**

Project Scope/Size	This project was ranked equally with TPC's other CAT 3 projects. Factors considered included the potential population that will be reached; the number of consumer visits/encounters; the number of individual providers recruited/trained, and the savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**
Project Investment	The expected investment to successfully implement this project and achieve milestones and metrics was ranked equally with TPC's other CAT 3 projects. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**3**

127378105.3.3	3.IT-10.1	Quality of Life	
Texas Panhandle Centers		127378105	
Related Category 1 Project(s):	127378105.2.2		
Starting Point/Baseline: 0	To be determined in DY 3		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Project data **Milestone 1 Estimated Incentive Payment:** *$59,689*	Process Milestone 2: P-2 Establish Baselines **Data Source:** Project data **Milestone 2 Estimated Incentive Payment:** *$138,374*	**Outcome Improvement Target 1** **IT-10.1 Quality of Life** **Improvement Target:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population for a TBD %. **Data source: V**alidated assessment tool for quality of life. **Outcome Improvement Target 1 Estimated Incentive Payment:** *$148,028*	**Outcome Improvement Target 2** **IT-10.1 Quality of Life** **Improvement Target:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population for a TBD %. **Data source: V**alidated assessment tool for quality of life. **Outcome Improvement Target 2 Estimated Incentive Payment:** *321,798*
DY 2 Estimated Outcome Amount: $59,689	**DY 3 Estimated Outcome Amount:** $138,374	**DY 4 Estimated Outcome Amount:** $148,028	**DY 5 Estimated Outcome Amount:** $321,798
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD :$667,889			

Outcome Measure Title: IT-10.1 Quality of Life
Performing Provider: Texas Panhandle Center/127378105
RHP Outcome Identification Number: 127378105.3.4 – **"PASS 2"**
Outcome Domain: *OD-10 Quality Of Life/ Functional Status*

Outcome Measure Description: *OD- 10 Quality Of Life/ Functional Status – IT-10.1 Quality of Life:* This Continuum of Care Program, shaped around critical Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving the quality of life of persons with behavioral health needs, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion. The vast majority of the target population for this program are low income; *92% of current clients have a 0$ maximum monthly fee for their services based on the DSHS/DADS Ability-to-pay fee schedule.*

Process Milestones – *DY2 and DY3:* These are the milestones that TPC as the performing provide will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- DY1-P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY2-P-2 Establish baseline rates

Outcome Improvement Targets – *DY4 and DY5*

- DY3 and DY4- IT-10.1 Quality of Life (*Standalone measure)*
    s. Demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for the target population for a TBD %
    t. Data source: A validated assessment tool for quality of life will be chosen as part of the planning process in year one. Validation assessment tools that will be vetted include AQoL, SF-36, 20 or 12, DSHS assessments, and similar assessment tools.

Rationale: The reasons for selecting the process milestones and outcome improvement targets that were chosen are:

- DY2- P-1 Project planning: To properly implement this project, many activities will need to occur that involve engaging stakeholders, identifying current capacity and needed resources, determining timelines and putting together implementation plans.
- DY3- P-2 Establish baseline rates during DY3 will allow the project to be implemented more effectively and efficiently.
- DY4&DY5- IT-10.1 Quality of Life (*Standalone measure)*: The Primary and Behavioral Health Integration Project, shaped around Community Needs identified in the RHP 12 Needs Assessment Survey, is aimed at improving client's quality of life, so we believe that measuring for improvement in quality of life can help shape the program in a positive fashion.
- The Implementation Target for this project will be improvement in quality of life for persons served through this program.. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Related Category 2 Project: 127378105.2.4

Project Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project was ranked equally with TPC's other CAT 3 projects. It achieves all of the following waiver goals: Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways; Improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth The project primarily impacts Medicaid and/or uninsured residents. The expected impact is very significant, as it addresses "cracks in the system" that need to be addressed. There strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact.	**3**
Addresses Community Need(s)	This project was ranked equally with TPC's other CAT 3 projects. Unique community need identification numbers the project addresses include: *CN.1- Severe primary care provider shortage Wait time, lack of insurance, access to care; CN.2- Lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact*; *CN.3- Poor insurance support or uninsured;*	**3**
Project Scope/Size	This project was ranked equally with TPC's other CAT 3 projects. Factors considered included the potential population that will be reached; the number of consumer visits/encounters; the number of individual providers recruited/trained, and the savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations	**3**

Project Investment	The expected investment to successfully implement this project and achieve milestones and metrics was ranked equally with TPC's other CAT 3 projects. Aspects considered included: Human resources; Equipment purchase and maintenance; Legal and professional fees; Time to implement; Risk assessment; and Organizational priorities.	**3**

127378105.3.4 – "PASS 2"	3.IT-10.1	Quality of Life	
Texas Panhandle Centers		127378105	
Related Category 1 or 2 Project(s):	127378105.2.3		
Starting Point/Baseline: 0	Baseline info: Baseline will be determined in DY2 as part of planning process		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015-9/30/2016)*
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source**: Project data **Milestone 1 Estimated Incentive Payment:** *$27,691*	**Process Milestone 1: P-2** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Project data **Milestone 1 Estimated Incentive Payment:** $61,453	**Outcome Improvement Target 1** **IT-10.1 Quality of Life** **Target Improvement:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by a TBD % **Data source:** Will use a validated assessment tool for quality of life. **Outcome Improvement Target 1 Estimated Incentive Payment:** $93,840	**Outcome Improvement Target 2** **IT-10.1 Quality of Life** **Target Improvement:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population by a TBD % **Data source:** Will use a validated assessment tool for quality of life. . **Outcome Improvement Target 2 Estimated Incentive Payment:** *$215,745*
DY 2 Estimated Outcome Amount: $27,691	**DY 3 Estimated Outcome Amount:** $61,453	**DY 4 Estimated Outcome Amount:** $93,840	**DY 5 Estimated Outcome Amount:** *$215,745*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD :$398,728			

Title of Outcome Measure (Improvement Target): IT-9.4 – Other Outcome Improvement Target
Performing Provider: Texas Tech Health Science Center/084563802
Unique RHP outcome identification number(s): 084563802.3.1
Outcome Domain: OD-9 Right Care, Right Setting

Outcome Measure Description:

IT-9.4 – Other Outcome Improvement Target: Evidence based, appropriate for proposed project, and meets the definition of an outcome measure

- TBD by performing provider

Process Milestones:

- DY3
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY4
  - IT-9.4 – Other Outcome Improvement Target
    - Patient's receiving care according to the standards set forth by NAPBC (35%)
- DY5
  - IT-9.4 – Other Outcome Improvement Target
    - Patient's receiving care according to the standards set forth by NAPBC (50%)

Rationale:

The process milestones chosen for DY3 are Project planning (P-1) and Dissemination of findings (P-5). Project planning (P-1) would involve engagement of stakeholders, to identify current capacity and needed resources so that practical timeline can be projected. Documentation of this process and plans will include meeting minutes, action items and reports. Dissemination of findings (P-5) would include feedback to the stakeholders and community representatives of the findings, execution status, "hits and

misses" of the project, and "coordination of referral process". This would allow the collaborative partners to learn from misses and plan on what could be done differently to enhance the outcomes intended.

The improvement target chosen for this project, planned by the TTUHSC-BCE, is a stand-alone measure targeting "right care" with the ultimate goal of enhancing delivery of high quality breast care to the population of TX-Panhandle. The quality measures for the specialty of breast disease (both benign and malignant) are standardized by the National Accreditation for Breast Centers (NAPBC). Therefore, the stand-alone measure chosen for this project is the percentage of patients with breast disease receiving standard of care as defined by the NAPBC. The goal is to deliver high quality standard of breast care to 50% of patients with breast disease by the end of the waiver. Numerator: The number of patients receiving care according to the standard of care determined by NAPBC (utilizes NQF measures). Denominator: All patients presenting with breast disease. The process milestone number 14 is chosen to track the development of the specialty training program; improvement measure 31 would track the number of trainees produced by the program that feed into the healthcare system, thereby improving quality of care delivery in TX-Panhandle.

Outcome Measure Valuation:

Achieves Waiver Goal: The Interdisciplinary Breast Fellowship program fully addresses the Triple Aim of assuring that patients receive high-quality, patient-centered care in most cost effective ways. With the rapid advancement in the field of breast disease specifically breast cancer, the provision of high quality care demands specialists trained with specific focus new and updated information and skill-set. Well-trained individuals can provide individualized patient-centered treatment options with newest and cost effective modalities. Panhandle has approximately 300 new breast cancers a year with a significant number of patients presenting at advanced stage. Outreach training of specialists would help promote preventive practices and increase survival in the region over long-term. **SCORE 5**

Addresses Community Needs: The project targets the area of cancer care identified as "Urgent" in the Community Needs Assessment (CN 6); TTUHSC-BCE is heavily engaged in preventive work and screening of underserved population of panhandle. 54% of our patients are underinsured. Producing highly qualified subspecialists with a program that emphasizes on best practices for indigent care will address a dire community need. **SCORE 4**

Project Scope/Size: This project is the very significant in terms of its reach of the TX-Panhandle community. These benefits will be long-term but long-lasting. Program graduates will not only serve the community during training but will be exposed to active recruitment and retention campaign which will vastly impact the isolated communities in the region. **SCORE 5**

Project Investment: The main expense of this project is the salary-line for the fellow. There are other programmatic costs expected in terms of faculty recruitment for training enhancement and exposure and contractual obligations from multidisciplinary training rotations. **SCORE 4**

084563802.3.1	*3.IT-9.4*	*Other Outcome Improvement Target*	
Texas Tech University Health Science Center - Amarillo			*084563802*
Related Category 1 or 2 Projects:	*084563802.1.1*		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1: P-1 Project Planning - Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Planning meeting documents, minutes and action items **Milestone 1 Estimated Incentive Payment:** $59,868 **Process Milestone 2: P-5** Disseminate Findings, including lessons learned and best practices, to stakeholders **Data Source:** Reporting meeting documents, minutes and project report **Milestone 2 Estimated Incentive Payment:** $59,868	**Outcome Improvement Target 1** **[IT-9.4]** Other Outcome Improvement Target **Improvement Target:** Patient's receiving care according to the standards set forth by NAPBC (35%) **Data Source:** Medical Records **Outcome Improvement Target 1 Estimated Incentive Payment:** $128,089	**Outcome Improvement Target 2** **[IT-9.4] Other** Outcome Improvement Target **Improvement Target:** Patient's receiving care according to the standards set forth by NAPBC (50%) **Data Source:** Medical Records **Outcome Improvement Target 2 Estimated Incentive Payment:** $278,455
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount:** $119,736	**Year 4 Estimated Outcome Amount:** $128,089	**Year 5 Estimated Outcome Amount:** $278,455
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $526,280			

Title of Outcome Measure: TBD
Performing Provider: Texas Tech Health Science Center/084563802
Unique RHP outcome identification number(s): 084563802.3.2

Outcome Measure Description: TBD

Process Milestones:

- DY3: P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – Develop and Test Data Systems
- DY3: P-2 – Establish Baseline Rates

Outcome Improvement Targets for each year: TBD
Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary for appropriateness and accuracy of the data
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals", "Addresses Community Needs", "Project Scope/Size", and "Project Investment".

Project Valuation:

Achieves Waiver Goal: SCORE 3

Addresses Community Needs: SCORE 3

Project Scope/Size: SCORE 3

Project Investment: SCORE 3

084563802.3.2	TBD	TBD	
Texas Tech University Health Sciences Center-Amarillo			084563802
Related Category 1 or 2 Projects:	084563802.1.2		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** EHR reports **Process Milestone 1 Estimated Incentive Payment *:*** $26,608 **Process Milestone 2** [P-3]: Develop and test data systems **Data Source:** EHR; Business Intelligence **Process Milestone 2 Estimated Incentive Payment:** $26,608 **Process Milestone 3** [P-2]: Establish baseline rates **Data Source:** EHR; Business Intelligence **Process Milestone 3 Estimated Incentive Payment:** $26,608	**Outcome Improvement Target 1** [TBD]: **Data Source:** TBD **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $85,393	**Outcome Improvement Target 2** [TBD]: **Data Source:** TBD **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $185,637
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount:** $79,824	**Year 4 Estimated Outcome Amount:** $85,393	**Year 5 Estimated Outcome Amount:** $185,637
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $350,853			

Title of Outcome Measure: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Performing Provider: Texas Tech Health Science Center – Amarillo/084563802
Unique RHP outcome identification number(s): 084563802.3.3
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description:

IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Percent Improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool.

Process Milestones:

- DY3:
  - P-1 - Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - Educate staff about initiative and survey
    - Identify certified survey administration vendor
  - P-2 - Establish baseline survey results

Outcome Improvement Targets for each year:

- DY4:

  IT-6.1 Rate 1: Increase survey scores in 1 of the 5 satisfaction domains by 5% over baseline established in DY3
- DY5:

  IT-6.1 Rate 2: Increase survey scores in at least 2 of the 5 satisfaction domains by 5% over baseline established in DY3

Rationale:

The delivery of modern healthcare is complex, with many potential process metrics to assess quality. It is intuitive that patients will gravitate to a healthcare delivery setting that is easily accessible, timely, and of high quality. For patients to routinely access medical care in the appropriate setting by the appropriate provider, though, they must perceive the care they receive in that setting is accessible, timely, and of high quality. If we can make the patient's medical home the best perceived healthcare delivery

setting, we can potentially reduce visits to less appropriate healthcare settings such as emergency departments. Individual process metrics may not accurately reflect the global perception a patient has of the healthcare they receive. Inclusion of a patient satisfaction survey tool allows us to measure and potentially improve that perception. Development of a patient centered medical home will likely improve patient satisfaction. Access to primary care has been identified as a critical need in our region. Continued monitoring and response to patient satisfaction scores will assist in meeting that need.

Rationale/Evidence: The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on clinical care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Achieves Waiver Goal: Improving patient satisfaction is related to Waiver goals. Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. The state healthcare transformation is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience. This will require a redesign of primary care to meet the needs of patients for timely, patient-centered, continuous, and coordinated care to enhance access to care regardless of type of insurance. The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve the practitioners in a clinic as well as the patients and their families or caregivers. An organizational strategy will be developed so that entities will manage patient experience and create avenues to implement the strategic plan/vision. Access to primary care was defined as a critical issue in our community. This project primarily addresses Community Needs Assessment Need CN1 (severe problems with access to primary care). Overtime, it is hoped that overall patient care is improved. As 75% of our patient population is economically disadvantaged, the population affected is the population intended by the initial waiver. **SCORE 4**

Addresses Community Needs: This project is anticipated to have a moderate impact on the community issue of primary care access for a focused population of pediatric patients. As the group impacted is one that is typically disenfranchised (the

economically disadvantaged) the actual impact should be higher than anticipated by the involvement of a single clinic. **SCORE 3**

Project Scope/Size: 7 general pediatricians, 3 mid-level providers, 17 resident physicians serving more than 7000 children with more than 20,000 general pediatric patient encounters. **SCORE 3**

Project Investment: This project will require dedicated administrator time (0.1 FTE), leadership team time (0.5 FTE x 4), and administrative support staff time (0.3 FTE). There is also cost to hiring a certified CAHPS vendor to administer the survey. **SCORE 3**

084563802.3.3	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Texas Tech Health Science Center Amarillo			084563802
Related Category 1 or 2 Projects:	084563802.2.1		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 P-1: Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans a. Educate staff about initiative and survey b. Identify certified survey administration vendor **Data Source:** a. Document educational sessions and strategies b. Document selected survey administration vendor **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $43,238 **Process Milestone 2 P-2:** Establish baseline survey results **Data Source:** Survey Results **Process Milestone 2 Estimated Incentive Payment:** $43,238	**Outcome Improvement Target 1 IT-6.1:** **Improvement Target:** Increase survey scores in 1 of the 5 satisfaction domains by 5% over baseline established in DY3. **Data Source:** Survey Results **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $92,509	**Outcome Improvement Target 2 IT-6.1:** **Improvement Target:** Increase survey scores in at least 2 of the 5 satisfaction domains by 5% over baseline established in DY3 **Data Source:** Survey Results **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $201,106
Year 2 Estimated Outcome Amount: $-0-	**Year 3 Estimated Outcome Amount:** $86,476	**Year 4 Estimated Outcome Amount:** $92,509	**Year 5 Estimated Outcome Amount:** $201,106

Title of Outcome Measure: IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate
Performing Provider Name/TPI: Texas Tech University Health Science Center – Amarillo/084563802
Unique RHP outcome identification number(s): 084563802.3.4
Outcome Domain: OD-3 – Potentially Preventable Re-Admissions – 30 day Readmission Rates

Outcome Measure Description:

IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate

- Decrease the number of readmissions to NWTH for patients 18 years and older, for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Process Milestones:

- **DY3:**

P1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. DY3 will be used for extensive and detailed planning of the project to determine how best to have the project achieve Category 3 related outcomes by DY 4 and 5.

P2- Establish Baseline rates - DY3 will require careful documentation of the population being studied as well as their readmission rates to then serve as the baseline for comparison during DY 4 and DY 5.

- **DY 4 & 5**
  - **IT-3.9 -** Chronic Obstructive Pulmonary Disease 30 day readmission rate
    - **The goal and metric to be reached is a reduction of this rate by 3% in DY4 (i.e. DY4 Rate/Rate 1(DY3 baseline) = 0.97 or less. Metric is 5% reduction in DY5 (i.e. DY5 Rate/Rate 1 (DY3 baseline rate) = 0.95 or less.**

Rationale:

Process milestones P1 and P2 were chosen to establish a baseline for addressing the regional community needs assessment (CN-9, CN-10) which identifies tobacco use as an important issue. Most recent data shows 42.9% have smoked, 32% smoke daily and 12% are still smoking "some of the time". Texas Tech does not currently have a project that addresses smoking cessation in any

fashion in the Amarillo area. By providing patients counsel and medication there is the expectation of significant participation by needy patients. Although there is an existing DSHS Quit Smoking phone line and program but it is not routinely utilized by the patients and there is no face-to-face recruitment, counsel or encouragement for them as planned in this project. The Texas DSHS reports under Preventable Hospitalizations section on their site www.dshs.state.tx.us/ph that between 2005-2010 there were the following number of hospitalizations in Potter and Randall counties that could have been prevented with better outpatient care and in this case specifically with cessation of smoking: COPD 1,705 with the average cost of a single COPD admission being $20,000 in charges. The site states: "communities can potentially prevent hospitalizations by encouraging education on smoking cessation and minimizing shortness of breath." Outcome Improvement Targets 1 and 2 were chosen to identify the reduction in Preventable Hospitalizations.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

- **Achieves Waiver Goal:** This project meets the Triple Aim goal by providing a high-quality smoking cessation project based on established models in the scientific literature. This project is completely patient-centered with goal of helping patients quit smoking. This is cost effective because the investment in time and personnel will be relatively small compared to the amount of money saved by reducing harm to patient's health and therefore reduced use of health resources, specifically hospitalizations for the same smoking-related diseases. This project improves care coordination within the system since patients will be contacted after discharge or enrollment in the project to encourage their compliance with smoking cessation and with use of their smoking cessation medication which will be provided free of charge. Medicaid and uninsured patients make up a significant proportion of the patients admitted to the Texas Tech internal medicine teams at Northwest Texas Hospital hence these needy patients will be provided improved care. A recent Cochrane Review ("Interventions for smoking cessation in hospitalized patients." Cochrane Database Syst Rev. (2012 May 16;5:CD001837.) determined after reviewing over 50 published trials that intensive smoking cessation counseling while in the hospital followed by post-discharge contact and inclusion of nicotine replacement increased quit rates. "Fifty trials met the inclusion criteria. Intensive counseling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials). A specific benefit for post-discharge contact compared with usual care was found in a subset of trials in which all participants received a counseling intervention in the hospital and were randomly assigned to post-discharge contact or usual care. No statistically significant benefit was found for less intensive counseling interventions. Adding nicotine

replacement therapy (NRT) to an intensive counseling intervention increased smoking cessation rates compared with intensive counseling alone (RR 1.54, 95% CI 1.34 to 1.79, six trials)." **SCORE 5**

- **Addresses Community Needs:** This project addresses three different community needs.CN.3 Poor insurance coverage or uninsured: many of the ill patients with smoking related complications including COPD, asthma, heart disease, hypertension, stroke, etc. have no way to pay for nicotine replacement therapy or for other medication if deemed necessary. This project will provide medication free of charge and will provide free support group sessions.CN.9 Tobacco use: rates of smoking in the community are listed above and this need will be addressed through this project. Due to the fact that high risk patients will be enrolled selectively the overall impact of the program will be much greater than if it was addressed to the general (smoking) public. CN.10 High prevalence of asthma and care issues. Due to many of the enrolled patients already having complications of their asthma or COPD due to smoking, this project specifically addresses this need in the community. Once again, there is recent, high quality evidence in the literature that a project like this can help patients quit smoking. (This is copied from above section:) A recent Cochrane Review ("Interventions for smoking cessation in hospitalized patients." Cochrane Database Syst Rev. 2012 May 16;5:CD001837.) determined after reviewing over 50 published trials that intensive smoking cessation counseling while in the hospital followed by post-discharge contact and inclusion of nicotine replacement increased quit rates. "Fifty trials met the inclusion criteria. Intensive counseling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials). A specific benefit for post-discharge contact compared with usual care was found in a subset of trials in which all participants received a counseling intervention in the hospital and were randomly assigned to post-discharge contact or usual care. No statistically significant benefit was found for less intensive counseling interventions. Adding nicotine replacement therapy (NRT) to an intensive counseling intervention increased smoking cessation rates compared with intensive counseling alone (RR 1.54, 95% CI 1.34 to 1.79, six trials)." **SCORE 4**

- **Project Scope/Size:** This project is starting out with a modest goal of offering the program to approximately 20% of high risk smokers admitted to the NWTH under the TTUHSC IM teams in the first year after implementation. This number will expand each year and over the life of the project should reach at least 31.5% of high risk smoking patients from the community who are already suffering the consequences of their smoking habit. If even 5% of these participating patients can be prevented

from being readmitted to the hospital due to their stopping smoking the savings will be significant. If the project proves highly successful in early years it could be expanded to include even more patients in later years. **SCORE 3**

- **Project Investment:**
  - Human resources – research technician, internal medicine residents, medical students, faculty members, pharmacy students, residents and faculty will all be required to carry out this project successfully
  - Equipment purchase and maintenance – equipment will include one or two laptop computers and medication will need to be purchased for each enrolled patient. **SCORE 2**

084563802.3.4	***IT-3.9***	***Chronic Obstructive Pulmonary Disease 30 day readmission rate***	
Texas Tech University School of Medicine – Amarillo			***084563802***
Related Category 1 or 2 Projects:	***084563802.2.2***		
Starting Point/Baseline:	***To be determined in DY3***		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Process Milestone 1: Milestone - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of planning efforts **Estimated Incentive Payment:** $46,564 **Process Milestone 2: Milestone - P-2** Establish baseline rates **Data Source:** Patient medical records; database **Estimated Incentive Payment:** $46,564	**Outcome Improvement Target 1** **[IT-3.9]** ***Chronic Obstructive Pulmonary Disease 30 day readmission rate*** **Improvement Target:** COPD 30 day readmission rate reduced by 3% over DY3 baseline rates comparing month by month. **Data Source:** Data will be requested from NWTH regarding for all discharges each month with a main diagnosis of COPD as well as the number of patients readmitted with the same diagnosis **Outcome Improvement Target 1** **Estimated Incentive Payment:** $99,625	**Outcome Improvement Target 2** **[IT-3.9]** ***Chronic Obstructive Pulmonary Disease 30 day readmission rate*** **Improvement Target:** COPD 30 day readmission rate reduced by 5% over DY3 baseline rates comparing month by month. . **Data Source:** Data will be requested from NWTH regarding for all discharges each month with a main diagnosis of COPD as well as the number of patients readmitted with the same diagnosis **Outcome Improvement Target 2** **Estimated Incentive Payment:** $216,576
Year 2 Estimated Outcome Amount: $ 0	Year 3 Estimated Outcome Amount: $93,128	Year 4 Estimated Outcome Amount: $ $99,625	Year 5 Estimated Outcome Amount: $216,576
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $409,329			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores
Performing Provider: Texas Tech Health Science Center – Amarillo/084563802
Unique RHP outcome identification number(s): 084563802.3.5 – **"PASS 2"**

Outcome Measure Description:

IT-6.1 Percent improvement over baseline of patient satisfaction scores

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool.

Process Milestones:

- DY2: P-1
  Project planning:
  - Educate staff about initiative and survey
  - Identify certified survey administration vendor
- DY3: P-2
  Establish baseline survey results

Outcome Improvement Targets for each year:

- DY4:
  IT-6.1 Rate 1: Increase survey scores in 1 of the 5 satisfaction domains by 5% over baseline established in DY3
- DY5:
  IT-6.1 Rate 2: Increase survey scores in at least 2 of the 5 satisfaction domains by 5% over baseline established in DY3

Rationale:

The reason we selected these milestones and improvement targets was to clearly identify, from the patients' perspective, whether or not we have met their needs within the medical home for the purpose of availability of specialty services. The delivery of modern healthcare is complex, with many potential process metrics to assess quality. It is intuitive that patients will gravitate to a healthcare delivery setting that is easily accessible, timely, and of high quality. For patients to routinely access medical care in the appropriate setting by the appropriate provider, though, they must *perceive* the care they receive in that setting is accessible, timely, and of high quality. If we can make the patient's medical home the best perceived healthcare delivery setting, we can potentially reduce visits to less appropriate healthcare settings such as emergency departments. Individual process metrics may not accurately

reflect the global perception a patient has of the healthcare they receive. Inclusion of a patient satisfaction survey tool allows us to measure and potentially improve that perception. Continued monitoring and response to patient satisfaction scores will assist in meeting that need.
Rationale/Evidence: The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on clinical care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:
Achieves Waiver Goal: Provision of needed specialty care to economically disadvantaged children directly relates to Waiver goals. Patient satisfaction is intuitively related to patient compliance and appropriate access of care. Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. The development of new specialty clinics are multi-year transformational efforts. Availability of some specialty care in our community is currently limited by provider availability. Improving access to specialty care will improve convenience of care and decrease direct cost to Medicaid by decreasing transportation reimbursement costs. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. Access to specialty care was defined as a severe issue in our community CN.5. This project directly addresses that issue. As 75% of our patient population is economically disadvantaged, the population affected is the population intended by the initial waiver.**SCORE 2**
Addresses Community Needs: Access to specialty care has been identified as a severe need in our region (CN.5). This project specifically addresses that need by improving pediatric endocrinology and pediatric urology service access.
SCORE 2
Project Scope/Size: We will be starting two new specialty clinics in our community, and assessing patient satisfaction with those services. **SCORE 2**
Project Investment : As we are also anticipating assessing patient satisfaction in our general pediatric clinic, many of the resources can be shared between the two projects. However, there will still be some administrative time required and there is also cost to hiring a certified CAHPS vendor to administer the survey. **SCORE 2**

*084563802.3.5 – **"PASS 2"***	*3.IT-6.1*	Percent improvement over baseline of patient satisfaction scores	
Texas Tech Health Science Center – Amarillo			*084563802*
Related Category 1 or 2 Projects:	*084563802.1.3*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of implementation plans, identification of satisfaction survey vendor. **Process Milestone 1 Estimated Incentive Payment:** $ 0	**Process Milestone 2: P-2 Establish Baseline Rates** **Data Source:** Survey tool **Process Milestone 2 Estimated Incentive Payment:** $ 91,296	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over patient satisfaction scores **Improvement Target:** Increase survey scores in 1 of the 5 satisfaction domains by 5% over baseline established in DY3 **Data Source:** Survey Tool **Outcome Improvement Target 1 Estimated Incentive Payment***:* $ 92,942	**Outcome Improvement Target 2** [IT-1.1]: Percent Improvement over patient satisfaction scores **Improvement Target:** Increase survey scores in at least 2 of the 5 satisfaction domains by 5% over baseline established in DY3 **Data Source:** Survey Tool **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $ 194,253
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount:** $ 91,296	**Year 4 Estimated Outcome Amount:** $ 92,942	**Year 5 Estimated Outcome Amount:** $ 194,253
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 378,491			

Outcome Measure Title: IT-8.9 Other Outcome Improvement Target: Breastfeeding
Performing Provider: Texas Tech Health Science Center - Amarillo/084563802
Unique RHP Outcome ID: 084563802.3.6– **"PASS 3"**

Outcome Domain:	OD-8 Perinatal Outcomes
Outcome Measure:	IT-8.9 Other Outcome Improvement Target: Breastfeeding
RHP Outcome Identification Number:	IT-8.9 084563802.3.6
Performing Provider:	Texas Tech University Health Sciences Center – Amarillo/084563802
TPI#	084563802
Outcome Measure Description:	By improving access to safety information regarding breastfeeding and breast milk pharmacology, we anticipate improving the rate of exclusive breast feeding in our community. Definitions of exclusive breastfeeding and calculation of rates will be taken from the Specifications Manual for Joint Commission National Quality Measures available at http://manual.jointcommission.org. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding). Baseline results of exclusive breastfeeding in our community will be established during DY3 by assessment at 2 weeks of age. By DY5, we anticipate a 5% increase in exclusive breastfeeding rates over baseline results. Results will be determined as follows: During DY3, a random representative chart review of Newborns coming to a general pediatric clinic for 2 week well child visit will be used to determine baseline exclusive breast feeding rate. A similar approach will be taken during DY5 to determine final results. a (DY 5 Results- Baseline Results)/ Baseline Results)= Percent change in exclusive breastfeeding rate b Data Source: EMR

Rationale: "Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007). A recent Cochrane review substantiates the benefits (Kramer et al., 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2010 and the CDC have also been active in promoting this goal." (1). The known benefits of breastfeeding are myriad and include decreased rates of obesity and common childhood infections. Our community needs assessment revealed a severe issue with inadequate access to perinatal care (CN7). This project directly addresses that need. Additionally, by decreasing childhood infection rates and obesity, improved breastfeeding rates would also improve the lack of access to primary care (CN1) by decreasing the frequency with which children need to be seen for sick visits. Eventually, this project would also address a lack of providers to manage diabetes (CN5) by improving obesity rates in formerly breast-fed patients.

(1) Specifications Manual for Joint Commission National Quality Measures (v2012B)

Project Valuation

		Score
Achieves Waiver Goals	This project addresses the Triple Aim of high quality and patient centered care in the most cost-effective ways. Improving breastfeeding rates directly improves the health of a child in a cost-effective preventive manner in both the short and long term. Although the primary project is not specifically targeted to economically disadvantaged populations, the dissemination of information via commonly utilized media (telephone and internet) improves access for all patients regardless of economic status. Additionally, this Category 3 project outcome (exclusive breastfeeding rate) will be measured using the records of a clinic that serves 75% Medicaid patients.	2
Addresses Community Needs:	Our community needs assessment revealed a severe issue with inadequate access to perinatal care (CN7). This project directly addresses that need. Additionally, by decreasing childhood infection rates and obesity, improved breastfeeding rates would also improve the lack of access to primary care (CN1) by decreasing the frequency with which children need to be seen for sick visits. Eventually, this project would also address a lack of providers to manage diabetes (CN5) by improving obesity rates in formerly breast-fed patients.	2
Project Scope/Size:	The Category 3 component of this project directly targets the breastfeeding rates in our community. The outcome will directly measure the impact of the interventions on a clinic with approximately 80 newborn patients per month. If program goals are achieved, we would anticipate a directly measured increase in exclusive breastfeeding of 190 patients over the four years. The overall impact in the community is difficult quantify.	2
Project Investment:	This project will require the addition of at least three trained staff members, as well as computer terminals, bandwidth assessment, and ongoing IT support.	3

084563802.3.6	*3.IT-8.9*	Increase Rate of Exclusive Breastfeeding	
Texas Tech Health Science Center – Amarillo			*084563802*
Related Category 1 or 2 Projects:	*084563802.1.4*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project Planning: Identify and train staff, identify technology resources, plan strategy for information dissemination. **Data Source:** Summary documentation of plans **Process Milestone 1 Estimated Incentive Payment:** $ 0	**Process Milestone 2: P-2** Establish baseline breastfeeding rates. **Data Source:** Electronic Medical Record **Process Milestone 2 Estimated Incentive Payment:** $ 8,492	**Outcome Improvement Target 1** [IT-8.9]: **Improvement Target:** Increase Breastfeeding rate by 2.5% over baseline **Data Source:** Electronic Medical Record Numerator: Calculated as (New Rates – Baseline Rate)/Baseline Rate Goal: Breastfeeding rate at 102.5% of Baseline **Outcome Improvement Target 1 Estimated Incentive Payment***:* $ 8,645	**Outcome Improvement Target 2** [IT-8.9]: **Improvement Target:** Increase Breastfeeding rate by 5% over baseline **Data Source:** Electronic Medical Record Numerator: Calculated as (New Rates – Baseline Rate)/Baseline Rate Goal: Breastfeeding rate at 105% of Baseline **Outcome Improvement Target 2 Estimated Incentive Payment***:* $ 18,069
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount:** $ 8,492	**Year 4 Estimated Outcome Amount:** $ 8,645	**Year 5 Estimated Outcome Amount:** $ 18,069
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 35,206			

Title of Outcome Measure: TBD
Performing Provider: Texas Tech Health Science Center – Lubbock/084599202
Unique RHP outcome ID: 084599202.3.1

Outcome Measure Description: TBD

Process Milestones:

- DY3:
    - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2 – Establish baseline rate(s)
    - P-3 – Develop and test data systems

Outcome Improvement Targets for each year: TBD

Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary appropriateness and accuracy of the data.
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

- **Achieves Waiver Goal: SCORE 3**
- **Addresses Community Needs: SCORE 3**
- **Project Scope/Size: SCORE 3**
- **Project Investment: SCORE 3**

084599202.3.1	TBD	TBD	
Texas Tech University Health Sciences Center-Lubbock			084599202
Related Category 1 or 2 Projects:	084599202.1.1		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** EHR reports **Process Milestone 1 Estimated Incentive Payment***:* $37,916 **Process Milestone 2 [P-3]: Develop and test data systems** **Data Source:** EHR; Business Intelligence **Process Milestone 2 Estimated Incentive Payment:** $37,916 **Process Milestone 3** [P-2]: Establish baseline rates for Rate 1 **Data Source:** EHR; Business Intelligence **Process Milestone 3 Estimated Incentive Payment:** $37,917	**Outcome Improvement Target 1** [TBD]: **Data Source:** TBD **Outcome Improvement Target 1 Estimated Incentive Payment***:* $121,685	**Outcome Improvement Target 2** [TBD]: **Data Source:** TBD **Outcome Improvement Target 3 Estimated Incentive Payment***:* $264,532
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount:** $113,749	**Year 4 Estimated Outcome Amount:** $121,685	**Year 5 Estimated Outcome Amount:** $264,532
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $499,966			

Title of Outcome Measure: TBD
Performing Provider: Texas Tech Health Science Center – Lubbock/084599202
Unique RHP outcome ID: 084599202.3.2

Outcome Measure Description: TBD

Process Milestones:

- DY3:
  - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rate(s)
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year: TBD

Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary appropriateness and accuracy of the data.
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

- **Achieves Waiver Goal: SCORE 3**
- **Addresses Community Needs: SCORE 3**
- **Project Scope/Size: SCORE 3**
- **Project Investment: SCORE 3**

084599202.3.2	TBD	TBD	
Texas Tech University Health Sciences Center-Lubbock			***084599202***
Related Category 1 or 2 Projects:	**084599202.1.2**		
Starting Point/Baseline:	**To be developed in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** EHR reports **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $37,916 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence **Process Milestone 2 Estimated Incentive Payment:** $37,916 **Process Milestone 3** [P-2]: Establish baseline rates for Rate 1 **Data Source:** EHR; Business Intelligence **Process Milestone 3 Estimated Incentive Payment:** $37,917	**Outcome Improvement Target 1** [TBD]: **Data Source:** TBD **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $121,685	**Outcome Improvement Target 2** [TBD]: **Data Source:** TBD **Outcome Improvement Target 3 Estimated Incentive Payment*:*** $264,532
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount:** $113,749	**Year 4 Estimated Outcome Amount:** $121,685	**Year 5 Estimated Outcome Amount:** $264,532
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $499,966			

Title of Outcome Measure: TBD
Performing Provider: Texas Tech Health Science Center/084599202
Unique RHP outcome identification number(s): 084599202.3.3

Outcome Measure Description: TBD

Process Milestones:

- DY3:
  - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rate(s)
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year: TBD

Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary appropriateness and accuracy of the data.
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on an equal score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

- **Achieves Waiver Goal:** SCORE 3
- **Addresses Community Needs:** SCORE 3
- **Project Scope/Size:** SCORE 3
- **Project Investment:** SCORE 3

084599202.3.3	***TBD***	**TBD**	
Texas Tech University Health Sciences Center-Lubbock			*084599202*
Related Category 1 or 2 Projects:	***084599202.1.3***		
Starting Point/Baseline:	***To be developed in DY3***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** EHR reports **Process Milestone 1 Estimated Incentive Payment *:*** $37,916 **Process Milestone 2** [P-3]: Develop and test data systems **Data Source:** EHR; Business Intelligence **Process Milestone 2 Estimated Incentive Payment:** $37,916 **Process Milestone 3 [P-2]: Establish baseline rates for Rate 1** **Data Source:** EHR; Business Intelligence **Process Milestone 3 Estimated Incentive Payment:** $37,917	**Outcome Improvement Target 1** [TBD]: **Data Source:** TBD **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $121,685	**Outcome Improvement Target 2** [TBD]: **Data Source:** TBD **Outcome Improvement Target 3 Estimated Incentive Payment*:*** $264,532
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount:** $113,749	**Year 4 Estimated Outcome Amount:** $121,685	**Year 5 Estimated Outcome Amount:** $264,532
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $499,966			

Title of Outcome Measure: TBD

Performing Provider: Texas Tech Health Science Center – Lubbock/084599202

Unique RHP outcome ID: 084599202.3.4

Outcome Measure Description: TBD

Process Milestones:

- DY3:
    - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2 – Establish baseline rate(s)
    - P-3 – Develop and test data systems

Outcome Improvement Targets for each year: TBD

Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary appropriateness and accuracy of the data.
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

- **Achieves Waiver Goal:** SCORE 3
- **Addresses Community Needs:** SCORE 3
- **Project Scope/Size:** SCORE 3
- **Project Investment:** SCORE 3

084599202.3.4	***TBD***	**TBD**	
Texas Tech University Health Sciences Center-Lubbock			***084599202***
Related Category 1 or 2 Projects:	***084599202.2.1***		

Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** EHR reports **Process Milestone 1 Estimated Incentive Payment:** $37,916 **Process Milestone 2** [P-3]: Develop and test data systems **Data Source:** EHR; Business Intelligence **Process Milestone 2 Estimated Incentive Payment:** $37,916 **Process Milestone 3** [P-2]: Establish baseline rates for Rate 1 **Data Source:** EHR; Business Intelligence **Process Milestone 3 Estimated Incentive Payment:** $37,917	**Outcome Improvement Target 1** [TBD]: **Data Source:** TBD **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $121,685	**Outcome Improvement Target 2** [TBD]: **Data Source:** TBD **Outcome Improvement Target 3 Estimated Incentive Payment*:*** $264,532
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount**: $113,749	**Year 4 Estimated Outcome Amount:** $121,685	**Year 5 Estimated Outcome Amount:** $264,532
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $499,966			

Title of Outcome Measure: TBD

Performing Provider: Texas Tech Health Science Center – Lubbock/084599202

Unique RHP outcome ID: 084599202.3.5

Outcome Measure Description: TBD

Process Milestones:

- DY3:
  - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rate(s)
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year: TBD

Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary appropriateness and accuracy of the data.
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

- **Achieves Waiver Goal:** SCORE 3
- **Addresses Community Needs:** SCORE 3
- **Project Scope/Size:** SCORE 3
- **Project Investment:** SCORE 3

084599202.3.5	*TBD*	**TBD**	
Texas Tech University Health Sciences Center-Lubbock			***084599202***
Related Category 1 or 2 Projects:	***084599202.2.2***		
Starting Point/Baseline:	***To be developed in DY3***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** EHR reports **Process Milestone 1 Estimated Incentive Payment:** $37,916 **Process Milestone 2** [P-3]: Develop and test data systems **Data Source:** EHR; Business Intelligence **Process Milestone 2 Estimated Incentive Payment:** $37,916 **Process Milestone 3** [P-2]: Establish baseline rates for Rate 1 **Data Source:** EHR; Business Intelligence **Process Milestone 3 Estimated Incentive Payment:** $37,917	**Outcome Improvement Target 1** [TBD]: Data Source: TBD Outcome Improvement Target 1 Estimated Incentive Payment*:* $121,685	**Outcome Improvement Target 2** [TBD]: Data Source: TBD Outcome Improvement Target 3 Estimated Incentive Payment*:* $264,532
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount:** $113,749	**Year 4 Estimated Outcome Amount:** $121,685	**Year 5 Estimated Outcome Amount:** $264,532
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $499,966			

Title of Outcome Measure (Improvement Target): TBD
Performing Provider: Texas Tech University Health Sciences Center-Lubbock/084599202
Unique RHP outcome identification number(s): 084599202.3.6 – **"PASS 2"**

Outcome Measure Description: TBD

Process Milestones:

- DY3:
  - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rate(s)
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year: TBD
Rationale:

- DY3: P-1 – This planning step is necessary to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-3 – This step is necessary appropriateness and accuracy of the data.
- DY3: P-2 – This step is necessary to allow for appropriate follow-up measures related to the outcome domain

Outcome Measure Valuation: TBD – Funds were allocated based on a score of 3 for each category. The categories include "Achieves Waiver Goals," "Addresses Community Needs," "Project Scope/Size," and "Project Investment."

Project Valuation:
Achieves Waiver Goal: SCORE 3
Addresses Community Needs: SCORE 3
Project Scope/Size: SCORE 3
Project Investment: SCORE 3

*084599202.3.6 – **"PASS 2"***	*TBD*	**TBD**	
Tech University Health Sciences Center-Lubbock			*084599202*
Related Category 1 or 2 Projects:	*084599202.2.3*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $33,727 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 2 Estimated Incentive Payment: $33,727 **Process Milestone 3** [P-2]: Establish baseline rates for Rate 1 Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $33,726	**Outcome Improvement Target 1** [TBD]: Data Source: TBD Outcome Improvement Target 1 Estimated Incentive Payment*:* $103,004	**Outcome Improvement Target 2** [TBD]: Data Source: TBD Outcome Improvement Target 3 Estimated Incentive Payment*:* $215,285
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $101,180	Year 4 Estimated Outcome Amount: $103,004	Year 5 Estimated Outcome Amount: $215,285
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $419,469			

Outcome Measure Title: IT-3.1. All Cause 30 Day Readmission Rate
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.1
Outcome Domain: OD-3 - Potentially Preventable Re-Admissions – 30 Day Readmission Rates (PPRs)

Outcome Measure Description:

Improvement Target: All Cause 30 day Readmission Rate

- Reduce unplanned all-cause 30-day readmissions. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

Process Milestones will be as follows:

- **P-2: Establish baseline rates**: Baseline rates will be measured using Premier Quality Advisor – our national database which produces benchmarked readmission data, stemming from our ADT information. All cause readmission is a recently added metric of readmission reduction, as part of healthcare reform; thus it is established and provides reliable comparisons for us.
- **P-1: Project planning:** Stakeholders to be engaged will include medical staff "Champions" for Readmission, via the Performance Improvement Committee of the medical staff; also Transition Coaches – RNs who serve on the readmission reduction committee. Once the baseline is established, additional resources (RNs, software, etc.) will be determined. This project will be supported by a Category 1 project, "Implement a Chronic Disease Mgt Registry." Improvement will be marked by reductions, following a PDCA cycle.

Outcome Measures will be as follows:

- **DY4 IT-3.1:** Reduce all unplanned Cause 30 day readmission rate by a TBD % over baseline
- **DY5 IT-3.1:** Reduce all unplanned Cause 30 day readmission rate by a TBD % over baseline.

Population for this project: This population will be the same as that of project 1.3. It will be all patients seen by a defined primary care clinic, diagnosed with a particular chronic disease, derived from the larger population of all patients of Lubbock County (funded, non-funded and under-funded).

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our Premier Quality Advisor system to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because UMC experiences thousands of readmissions annually across a broad scope of diagnoses. In comparison to national benchmarks, a significant number of them are expected due to patient acuity. Our goal is to reduce, not eliminate all cause 30 day readmissions. The rationale rests twofold: a) Readmissions are expensive for payers (Medicare) and for the facility (Medicaid, unfunded); and b) Readmissions, if unnecessary are not in the best interest of patient safety. We have seen a reduction in readmissions over the past two years, yet we have room for improvement. Because readmissions generally approach the ER, these also create a patient flow challenge in that environment as well.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Reducing 30 day all cause readmissions impacts all of the goals of Triple Aim. Patients who do not need readmission are safer outside the acute care facility; Transition Coaches provide patient-centered care (medications, follow up appointments, nutrition assistance, etc.); and avoiding readmissions reduces cost to payers. The infrastructure will be improved, via a "safety net" of care givers (coaches) who are positioned to assist patients, and to avoid unnecessary readmissions. There is a growing body of evidence (as well as experience gained thus far at UMC) substantiating the positive affect of education, coaching and transition assistance from the hospital bed to home, on readmission reduction.	**5**
Addresses Community Need(s)	Per the RHP 12 Needs Assessment, many of the chronic diseases which manifest higher readmission rates are prevalent in our area. Examples: Lubbock BRFSS data indicates 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is higher than state average. Incidence of heart disease in Lubbock is 7.1% as compared to a national average of 4%. This project directly addresses the care of chronically ill patients – proactive care, to avoid readmissions. This project is expected to move the dial as each reduced readmission equates to reduced cost and improved health.	**5**
Project Scope/Size	Because this project addresses ALL cause readmission, it is not limited to diagnoses targeted by CMS (AMI, PN and CHF). Thus, the scope will be broad, the resources considerable and the potential impact, large. This project will entail outreach to the community – phone visits, coaching, in-home contacts, and pharmacy intervention.	**5**

Project Investment	The project rests upon a Category 1 project (Disease Registry). In addition to the registry purchase, the project entails human resources (RN coaches). Because this is ALL cause readmission, HR will be the largest component.	4

137999206.3.1	3.IT-3.1	All Cause 30-day Readmission Rate	
University Medical Center		137999206	
Related Category 1 or 2 Project(s):	137999206.1.1		
Starting Point/Baseline:	Baseline TBD in DY2		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 P-2: Establish baseline rates **Data Source:** Premier Clinical Advisor Reports **Process Milestone 1 Estimated Incentive Payment:** $288,197	**Process Milestone 2** P-1: Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Documentation of Project planning process. **Process Milestone 2 Estimated Incentive Payment:** $334,057	**Outcome Improvement Target 1:** [IT-3.1]All Cause 30 day readmission rate **Improvement Target:** Reduce All unplanned Cause 30 day readmission rate by a TBD % over baseline **Data Source:** EMR, claims and Premier Clinical Advisor Reports **Estimated Outcome Improvement Target Incentive Payment:** $536,046	**Outcome Improvement Target 2:** [IT-3.1]All Cause 30 day readmission rate **Improvement Target:** Reduce All unplanned Cause 30 day readmission rate by a TBD % over baseline **Data Source:** EMR, claims and Premier Clinical Advisor Reports **Estimated Outcome Improvement Target Incentive Payment:** $1,281,848
DY 2 Estimated Outcome Amount: $288,197	**DY 3 Estimated Outcome Amount:** $334,057	**DY 4 Estimated Outcome Amount:** $536,046	**DY 5 Estimated Outcome Amount:** $1,281,848
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,440,148			

Outcome Measure Title: IT-9.2. ED Appropriate Utilization
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.2
Outcome Domain: OD-9 - Right Care, Right Setting

Outcome Measure Description:

Improvement Target: IT- 9.2 ED Appropriate Utilization

- Reduce all ED visits (including ACSC)

Process Milestones will be as follows:

- **DY2 - P-2:** Establish baseline rates: Baseline rates will be measured using ED triage data – our ED Database. The RHP 12 Community Needs Identification ID # CN.1 and CN.3 sites an access to care problem for the unfunded and underfunded people of this area. This problem leads to an inappropriate use of the ED for semi-urgent or non-urgent care.

- **DY3 - P-1**: Project planning: Stakeholders to be engaged will include ED medical staff, nursing staff and the Telephone Triage staff. Once the baseline is established, additional resources (RNs, software, etc.) will be determined. This project will be supported by a Category 1 project, "Enhance Urgent Medical Advice". Improvement will be marked by reductions in Semi-urgent and non-urgent patients presenting to the ED Triage desk.

Outcome Improvement Targets for each year:

- **DY4 – IT – 9.2 -** Reduce all ED visits by a TBD % of the baseline for targeted population
- **DY5 – IT – 9.2 -** Reduce all ED visits by a TBD % of the baseline for targeted population

Population for this project: This population for this project will be underfunded and non-funded patients presenting to the ED who are triage as a semi-urgent or non-urgent complaint.

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our ED triage data/ED database to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because UMC experiences thousands of patients annually who seek semi urgent or non-urgent care from the ED. Most of the people in this category are underfunded or non-funded and have l137imited options to access care advice. The rationale rests twofold: a) Emergency Department care is an expensive option for less than urgent medical problems and b) Waiting long waits in the ED waiting room is not in the best interest of patient safety. Further, these less than urgent conditions create a patient flow challenge in that environment as well.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The project Goal is to provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the Emergency Center (EC) can be reduced. The advice line provides callers with direct access to a registered nurse who can address their specific health needs with an on-demand service. The call center will be marketed to Medicare and Medicaid patients as well as the un or underinsured patients of our community. These populations specifically need help in making decisions to access the most appropriate entry into the healthcare system. The volume of semi urgent and non-urgent patients being triaged by the UMC EC in 2011 is 20,694 (29%). Of this 29%, 713 patients left without being seen (LWBS) (713 is 25% of the LWBS population). The Medicare, Medicaid and CHIP patients represent 32% of those who have been triaged as semi-urgent and non-urgent yet only 9 people out of this payer mix left without being seen. This underscores their reality that they have nowhere else to go and decide to wait it out in the EC.	5
Address Community Needs:	The RH12 Community Needs Identification #'s affected are CN.1; decreasing wait times in the EC and helping with access to care. CN.2; helping callers to obtain appointments. Our area survey reflects 19% of our population finds it difficult to obtain medical care. The call center can help obtain an appointment, decrease language barriers, and decrease long waits in the Emergency center.	5
Project Scope/Size:	The call center represents one of our larger projects in that a significant amount personnel, Office equipment and software programs will be required. When expanding this project to meet patient demand, it will require more nurses and more software licenses. Our initial outreach will be to patients who are discharged from the hospital, frequent users of the EC and our Medicare / Medicaid program contacts. It is not clear in the literature how many EC visits will be avoided so it is difficult to project any savings. Some have experienced more volume in the EC since the call center allows you to see those who are now leaving without being seen because it helped to remove those in the waiting room who should not have been there anyway.	5
Project Investment:	The initial investment required of this project is projected at $241,000. Hire a Director and the initial 4.2 staff members for 24/7 coverage ($110,000), Set up an office with phone lines and equipment($6,000) and purchase/install software ($125,000)	5

137999206.3.2	**3.IT-9.2**	**ED Appropriate Utilization**	
University Medical Center		**137999206**	
Related Category 1 or 2 Project(s):	**137999206.1.2**		
Starting Point/Baseline:	**Baseline TBD in DY2**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 **P-2: Establish baseline rates** **Data Source:** ED triage data/ED database **Process Milestone 1 Estimated Incentive Payment:** *$303,365*	Process Milestone 2 P-1: Project planning - engage stakeholders (Teletriage staff and ED Staff), identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Meeting minutes, project projections/timelines **Process Milestone 2 Estimated Incentive Payment:** *$351,639*	***Outcome Improvement Target 1:*** *[IT-9.2]* *ED Appropriate Utilization* **Improvement Target:** Reduce all ED visits by a TBD % of the baseline for targeted population **Data Source:** ED triage data/ED database **Estimated Outcome Improvement Target Incentive Payment:** *$564,259*	***Outcome Improvement Target 2:*** *[IT-9.2]* *ED Appropriate Utilization* **Improvement Target:** Reduce all ED visits by a TBD % of the baseline for targeted population **Data Source:** ED triage data/ED database **Estimated Outcome Improvement Target Incentive Payment:** *$1,349,314*
DY 2 Estimated Outcome Amount: $303,365	**DY 3 Estimated Outcome Amount:** $351,639	**DY 4 Estimated Outcome Amount**: $564,259	**DY 5 Estimated Outcome Amount**: $1,349,314
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,568,577			

Project Title: IT-4.4 Surgical Site Infections (SSI) Rates
Performing Provider: University Medical Center - 137999206
RHP Outcome Identification Number: 137999206.3.3
Outcome Domain: OD-4 - Potentially Preventable Complications and Healthcare Acquired Conditions

Outcome Measure Description:

Improvement Target: IT-4.4 Surgical Site Infections (SSI) Rates –Process Milestones will be as follows:

- Reduce the number of cases of SSI as designated by IQR criteria

Process Milestones

- **DY2**
  - **P-2: Establish baseline rates:** Baseline rates are typically measured using Medmined data system which measures and benchmarks our infection rate(s) to those of comparable facilities. Depending on the prevalence of SSI's, the baseline will also include individually abstracted cases of post-surgical infections. Abstraction is the best way to investigate cause and effect.
- **DY3**
  - **P-1: Project planning:** As this is housed principally in the OR suites, our "Champions" for SSI rates will be surgical members of the Infection Control and Performance Improvement Committees. Resources will be identified after analysis of surveillance data, and study of options available (enhancements to air flow, chemical products, etc.). Improvement will be marked by reductions, following a PDCA cycle.

- **Outcome Improvement targets for each year:**
  - **DY4:**
    - **IT-4.4** - Reduce the number of cases of SSI by a TBD % from baseline
  - **DY5:**
    - **IT-4.4** – Reduce the number of cases of SSI by a TBD % from baseline

Population for this project: This population is the same as the population defined in project 1.10. It will be all inpatients treated at UMC including funded, non-funded and under-funded patients.

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our Premier Quality Advisor system to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because surgical site infections cost lives, extended hospital stays, and dollars for users and payers. We trust our current data base, thus we have rationale with valid numbers from Medmined. In comparison to academic hospitals, we have considerable room for improvement, based on Jan-Dec 2011 data. On average, patients with a nosocomial infection marker (NIM) cost $10,000 more than patients without (DRG profit/loss). There is a high correlation between NIMs and extended LOS and increased cost.

Related Category 1 Project:

- ***137999206.1.2 - Enhance improvement capacity within people***

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Reducing surgical site infections has a direct correlation to reduced length of stay, improved mortality, reduced readmission and particularly reduced healthcare cost. This is why hospitals were required in Jan 2012 to report surgical site infections. Thus, this project impacts Triple Aim. This project is designed to achieve SSI rate reduction, specific to diagnoses, provider, physician location, etc. The result of this project, which requires significant analysis to arrive at "cause and effect" results, will be improved healthcare (reduced risk) for all patients including Medicaid and under/unfunded. Infrastructure improvements will range from physical plant to cleaning/sterilizing technique to personnel conducting surveillance.	**5**
Addresses Community Need(s)	Given that each surgical site infection has the potential for serious complication and/or death, the impact even though stemming from a small number of SSIs, can still be great. Evidence is clear – per CDC, NSHN and AHRQ as to the increased cost and health risk associated with SSIs. Currently, UMC is monitoring and reporting: total knees, total hips, colon, CABG and hysterectomy. Two of these (TK and TH) tie directly to CMS readmission reduction metrics, yet another way in which this project benefits the community.	**5**
Project Scope/Size	UMC has seen considerable improvement in certain SSI rates such as CABG and hysterectomies. However, room for improvement remains for total hips, total knees and other. The number of patients affected is small; the impact on those individuals is not.	**3**

Project Investment	This project rests upon a Category 1 project, Enhance Performance Improvement and Reporting Capacity. This project will entail considerable man hours to abstract chart data for hospital discharges as well as post discharge data to determine prevalence of and cause of SSIs. Once the underlying causes are discovered, whether they are physical, procedural or personnel, resources will be associated with each. It is somewhat difficult to estimate at the outset.	**4**

137999206.3.3	3.IT-4.4	Surgical Site Infection Rates	
University Medical Center		137999206	
Related Category 1 or 2 Project(s):	137999206.1.3		
Starting Point/Baseline:	Baseline TBD in DY2		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 P-3.2: Establish baseline rates **Data Source:** Abstracted reports and submissions to NSHN **Process Milestone 1 Estimated Incentive Payment** *$257,860*	**Process Milestone 2** P-3.1: Project planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data **Source:** Meeting minutes, project projections/timelines **Process Milestone 2 Estimated Incentive Payment:** $298,894	**Outcome Improvement Target 1:** IT-4.4 Surgical site infections rates. **Improvement Target:** Reduce the number of cases of SSI by a TBD % from baseline **Data Source:** EMR, Claims, IQR/NHSN data, Abstracted reports and submissions to NSHN **Estimated Outcome Improvement Target Incentive Payment:** $479,620	**Outcome Improvement Target 2:** IT-4.4 Surgical site infections rates. **Improvement Target:** Reduce the number of cases of SSI by a TBD % from baseline **Data Source:** EMR, Claims, IQR/NHSN data, Abstracted reports and submissions to NSHN **Estimated Outcome Improvement Target Incentive Payment:** $1,146,917
DY 2 Estimated Outcome Amount: $257,860	**DY 3 Estimated Outcome Amount:** $298,894	**DY 4 Estimated Outcome Amount:** $479,620	**DY 5 Estimated Outcome Amount:** $1,146,917
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *$2,183,291*			

Outcome Measure Title: IT-1.12 Diabetes Care – Retinal Eye Exam
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.4
Outcome Domain: OD-1 - Primary Care and Chronic Disease Management

Outcome Measure Description:

Improvement Target: IT-1.12 Diabetes Care – Retinal Eye Exam

- Increase the number of eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:
  - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
  - A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year.

Process Milestones will be as follows:

- **DY2 - P-2:** Establish baseline rates: Baseline rates will be established via EMR for the designated outpatient areas (clinics) selected for this project. Baseline will also be drawn from diabetic patients within the Chronic Care Disease Registry (Related project 1.3).
- **DY3 - P-1:** Project planning: Stakeholders to be engaged will include medical providers in selected outpatient clinics, RN coordinators (coaches) assigned to manage this population via the disease registry, and educators in the hospital.

Outcome Improvement Targets for each year:

- **DY4 – IT-1.12** Diabetes Care: Retinal eye exam – Increase the number of eye screening for diabetic retinal disease in patients with evidence of retinopathy by a TBD % over baseline
- **DY5 - IT-1.12** Diabetes Care: Retinal eye exam – Increase the number of eye screening for diabetic retinal disease in patients with evidence of retinopathy by a TBD % over baseline

Population for this project: The population will be all patients 18 through 75 years of age, seen/managed in designated ambulatory clinics within PNS or Texas Tech.

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our E.M.R. and chronic disease registry to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause for Hispanics – who are heavily represented within the Lubbock community. The RHP 12 Needs Assessment Summary indicated that Lubbock BRFSS data says 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 as compared to Texas at 26.5/100,000. Diabetes, particularly among the Medicaid and under/unfunded population is costly to providers and restrictive to patients who cannot afford a clinic visit or have difficulty accessing a free clinic. Diabetes is expected to grow; these exams are currently not pursued aggressively. There is considerable room for improvement.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The goal of this project is to prevent/stop/slow the acuity of diabetes in a population diagnosed with diabetes. Diabetes is rampant and expected to increase. This project can meet all of the Triple Aim goals. Cost will be impacted/reduced as patients' symptoms are addressed sooner (ambulatory) rather than later (inpatient). This project will benefit from patients' responsibility to "self-manage" their diagnosis and associated care goals, which relates this project to 2.2 Expand Chronic Care Mgt Models. The information provided via the exams will be within the common EMR, thus facilitating an improved continuum of care.	**5**
Addresses Community Need(s)	The RHP 12 Needs Assessment Summary indicated that Lubbock BRFSS data says 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 as compared to Texas at 26.5/100,000. We know from our case managers that compliance with medication/therapy is a challenge for this population. This project will benefit from the work of RN coordinators or coaches – they will reach out to diabetic patients beyond the typical office visit "reminder."	**5**
Project Scope/Size	This is a large project because the denominator (patients diagnosed with diabetes) is large, and growing. Outreach to this population will be supported by the disease registry and accomplished by RN coordinators and coaches whose goal is to accomplish these exams. The "downstream" savings will result from reduced admissions, reduced urgent clinic and hospital visits, stemming from timely and compliant exams and screenings.	**5**
Project Investment	Much like the Readmission Reduction project (IT-3.1) this project requires relationships to be established between diabetic patients and caregivers, namely RNs who conduct outreach, support, education, etc. This project will be heavily resourced by personnel, the number of which will be dependent upon baseline calculations.	**5**

137999206.3.4	**3.IT-1.12**	**Diabetes Care – Retinal Eye Exam**	
University Medical Center		**137999206**	
Related Category 1 or 2 Project(s):	**137999206.2.1**		
Starting Point/Baseline:	**Baseline TBD during DY2**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 P-2 Establish baseline rates: **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Process Milestone 1 Estimated Incentive Payment:** $101,122	**Process Milestone 2 P-1:** Project planning: Stakeholders to be engaged will include medical providers in selected outpatient clinics, RN coordinators (coaches) assigned to manage this population via the disease registry, and educators in the hospital. **Data Source:** Documentation of Project planning process. **Process Milestone 2 Estimated Incentive Payment:** $117,213	**Outcome Improvement Target 1: [IT-1.12] Diabetes Care – Retinal Eye Exam** **Improvement Target:** Increase the number of eye screening for diabetic retinal disease in patients with evidence of retinopathy by a TBD % over baseline Data Source: E.M.R. and Chronic Electronic Medical Record & Chronic Care Disease Registry **Estimated Outcome Improvement Target Incentive Payment:** $188,086	**Outcome Improvement Target 2: [IT-1.12**] **Diabetes Care – Retinal Eye Exam** **Improvement Target:** Increase the number of eye screening for diabetic retinal disease in patients with evidence of retinopathy by a TBD % over baseline Data Source: Electronic Medical Record & Chronic Care Disease Registry **Estimated Outcome Improvement Target Incentive Payment:** $449,771
DY 2 Estimated Outcome Amount: $101,122	**DY 3 Estimated Outcome Amount:** $117,213	**DY 4 Estimated Outcome Amount:** $188,086	**DY 5 Estimated Outcome Amount:** $449,771
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $856,192			

Outcome Measure Title: IT-1.13 Diabetes Care – Foot Exam
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.5
Outcome Domain: OD-1 - Primary Care and Chronic Disease Management

Outcome Measure Description:

Improvement Target: IT-1.13 Diabetes Care – Foot Exam

- Increase the number of foot exams for patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.

Process Milestones will be as follows:

- **DY2 - P-2:** Establish baseline rates: Baseline rates will be established via EMR for the designated outpatient areas (clinics) selected for this project. Baseline will also be drawn from diabetic patients within the Chronic Care Disease Registry (Related project 1.3).
- **DY3 - P-1:** Project planning: Stakeholders to be engaged will include medical providers in selected outpatient clinics, RN coordinators (coaches) assigned to manage this population via the disease registry, and educators in the hospital.

Outcome Improvement Targets for each year:

- **DY4 – IT-1.13** Increase the number of foot exams for patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) by a TBD% over baseline
- **DY5 - IT-1.13** Increase the number of foot exams for patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) by a TBD% over baseline.

Population for this project: The population will be all patients 18 through 75 years of age, seen/managed in designated ambulatory clinics within PNS or Texas Tech.

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our E.M.R. and chronic disease registry to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause for Hispanics – who are heavily represented within the Lubbock community. The RHP 12 Needs Assessment Summary indicated that Lubbock BRFSS data says 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 as compared to Texas at 26.5/100,000. Diabetes, particularly among the Medicaid and under/unfunded population is costly to providers and restrictive to patients who cannot afford a clinic visit or have difficulty accessing a free clinic. Diabetes is expected to grow; these exams are currently not pursued aggressively. There is considerable room for improvement.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The goal of this project is to prevent/stop/slow the acuity of diabetes in a population diagnosed with diabetes. Diabetes is rampant and expected to increase. This project can meet all of the Triple Aim goals. Cost will be impacted/reduced as patients' symptoms are addressed sooner (ambulatory) rather than later (inpatient). This project will benefit from patients' responsibility to "self-manage" their diagnosis and associated care goals, which relates this project to 2.2 Expand Chronic Care Mgt Models. The information provided via the exams will be within the common EMR, thus facilitating an improved continuum of care.	**5**
Addresses Community Need(s)	The RHP 12 Needs Assessment Summary indicated that Lubbock BRFSS data says 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 as compared to Texas at 26.5/100,000. We know from our case managers that compliance with medication/therapy is a challenge for this population. This project will benefit from the work of RN coordinators or coaches – they will reach out to diabetic patients beyond the typical office visit "reminder."	**5**
Project Scope/Size	This is a large project because the denominator (patients diagnosed with diabetes) is large, and growing. Outreach to this population will be supported by the disease registry and accomplished by RN coordinators and coaches whose goal is to accomplish these exams. The "downstream" savings will result from reduced admissions, reduced urgent clinic and hospital visits, stemming from timely and compliant exams and screenings.	**5**
Project Investment	Much like the Readmission Reduction project (IT-3.1) this project requires relationships to be established between diabetic patients and caregivers, namely RNs who conduct outreach, support, education, etc. This project will be heavily resourced by personnel, the number of which will be dependent upon baseline calculations.	**5**

137999206.3.5	3.IT-1.13	Diabetes Care – Foot Exam	
University Medical Center		137999206	
Related Category 1 or 2 Project(s):	137999206.2.1		
Starting Point/Baseline:	Baseline TBD during DY2		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 **P-2:** Establish baseline rates: Baseline rates **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Process Milestone 1 Estimated Incentive Payment:** $101,122	**Process Milestone 2** **P-1:** Project planning: Stakeholders to be engaged will include medical providers in selected outpatient clinics, RN coordinators (coaches) assigned to manage this population via the disease registry, and educators in the hospital. **Data Source:** Documentation of Project planning process. **Process Milestone 2 Estimated Incentive Payment:** $117,213	**Outcome Improvement Target 1: [IT-1.13]** **Improvement Target:** Increase the number of foot exams for patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) by a TBD% over baseline **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Estimated Outcome Improvement Target Incentive Payment:** $188,086	**Outcome Improvement Target 2: [IT-1.13]** **Improvement Target:** Increase the number of foot exams for patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) by a TBD% over baseline **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Estimated Outcome Improvement Target Incentive Payment:** $449,771
DY 2 Estimated Outcome Amount: $101,122	**DY 3 Estimated Outcome Amount:** $117,213	**DY 4 Estimated Outcome Amount:** $188,086	**DY 5 Estimated Outcome Amount:** $449,771
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $856,192			

Outcome Measure Title: IT-1.14 Diabetes Care – Microalbumin/Nephropathy
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.6
Outcome Domain: OD-1 - Primary Care and Chronic Disease Management

Outcome Measure Description:

Improvement Target: IT-1.14 Diabetes Care – Microalbumin/Nephropathy

- Increase the % of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy

Process Milestones will be as follows:

- **DY2 - P-2**: Establish baseline rates: Baseline rates will be established via EMR for the designated outpatient areas (clinics) selected for this project. Baseline will also be drawn from diabetic patients within the Chronic Care Disease Registry (Related project 1.3).
- **DY3 - P-1:** Project planning: Stakeholders to be engaged will include medical providers in selected outpatient clinics, RN coordinators (coaches) assigned to manage this population via the disease registry, and educators in the hospital.

Outcome Improvement Targets for each year:

- **DY4 – IT-1.14** Diabetes Care: Microalbumin/Nephropathy - Increase the % of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy by a TBD % over baseline
- **DY5 - IT-1.14** Diabetes Care: Microalbumin/Nephropathy Increase the % of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy by a TBD % over baseline

Population for this project: The population will be all patients 18 through 75 years of age, seen/managed in designated ambulatory clinics within PNS or Texas Tech.

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our E.M.R. and chronic disease registry to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause for Hispanics – who are heavily represented within the Lubbock community. The RHP 12 Needs Assessment Summary indicated that Lubbock BRFSS data says 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 as compared to Texas at 26.5/100,000. Diabetes, particularly among the Medicaid and under/unfunded population is costly to providers and restrictive to patients who cannot afford a clinic visit or have difficulty accessing a free clinic. Diabetes is expected to grow; these exams are currently not pursued aggressively. There is considerable room for improvement.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	The goal of this project is to prevent/stop/slow the acuity of diabetes in a population diagnosed with diabetes. Diabetes is rampant and expected to increase. This project can meet all of the Triple Aim goals. Cost will be impacted/reduced as patients' symptoms are addressed sooner (ambulatory) rather than later (inpatient). This project will benefit from patients' responsibility to "self-manage" their diagnosis and associated care goals, which relates this project to 2.2 Expand Chronic Care Mgt Models. The information provided via the exams will be within the common EMR, thus facilitating an improved continuum of care.	**5**
Addresses Community Need(s)	The RHP 12 Needs Assessment Summary indicated that Lubbock BRFSS data says 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 as compared to Texas at 26.5/100,000. We know from our case managers that compliance with medication/therapy is a challenge for this population. This project will benefit from the work of RN coordinators or coaches – they will reach out to diabetic patients beyond the typical office visit "reminder."	**5**
Project Scope/Size	This is a large project because the denominator (patients diagnosed with diabetes) is large, and growing. Outreach to this population will be supported by the disease registry and accomplished by RN coordinators and coaches whose goal is to accomplish these exams. The "downstream" savings will result from reduced admissions, reduced urgent clinic and hospital visits, stemming from timely and compliant exams and screenings.	**5**
Project Investment	Much like the Readmission Reduction project (IT-3.1) this project requires relationships to be established between diabetic patients and caregivers, namely RNs who conduct outreach, support, education, etc. This project will be heavily resourced by personnel, the number of which will be dependent upon baseline calculations.	**5**

137999206.3.6	**3.IT-1.14**	**Diabetes Care – Microalbumin/Nephropathy**	
University Medical Center		137999206	
Related Category 1 or 2 Project(s):	137999206.2.1	**2.2.1**	**Redesign the outpatient delivery system to coordinate care for patients with chronic diseases**
Starting Point/Baseline:	**Baseline TBD**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 P-2: Establish baseline rates: **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Process Milestone 1 Estimated Incentive Payment***: $101,122*	**Process Milestone 2** P-3.1: Project planning: Stakeholders to be engaged will include medical providers in selected outpatient clinics, RN coordinators (coaches) assigned to manage this population via the disease registry, and educators in the hospital. **Data Source:** Documentation of Project planning process. **Process Milestone 2 Estimated Incentive Payment:** *$117,213*	**Outcome Improvement Target 1: [IT-1.14]** Diabetes Care – Microalbumin/Nephropathy Improvement Target: Increase the % of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy by a TBD % over baseline **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Estimated Outcome Improvement Target Incentive Payment***: $188,086*	**Outcome Improvement Target 2: [IT-1.14]** Diabetes Care – Microalbumin/Nephropathy Improvement Target: Increase the % of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy by a TBD % over baseline **Data Source:** Electronic Medical Record & Chronic Care Disease Registry **Estimated Outcome Improvement Target Incentive Payment:** *$449,771*
DY 2 Estimated Outcome Amount: $101,122	**DY 3 Estimated Outcome Amount:** $117,213	**DY 4 Estimated Outcome Amount**: $188,086	**DY 5 Estimated Outcome Amount**: $449,771
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $856,192			

Outcome Measure Title: IT-3.1. All Cause 30 Day Readmission Rate
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.7
Outcome Domain: OD-3 Potentially Preventable Re-Admissions – 30 Day Readmission Rates (PPRs)

Outcome Measure Description:

Improvement Target: All Cause 30 day Readmission Rate

- Reduce unplanned all-cause 30-day readmissions. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

Process Milestones will be as follows:

- **P-2: Establish baseline rates:** Baseline rates will be measured using Premier Quality Advisor – our national database which produces benchmarked readmission data, stemming from our ADT information. All cause readmission is a recently added metric of readmission reduction, as part of healthcare reform; thus it is established and provides reliable comparisons for us.
- **P-1: Project planning**: Stakeholders to be engaged will include medical staff "Champions" for Readmission, via the Performance Improvement Committee of the medical staff; also Transition Coaches – RNs who serve on the readmission reduction committee. Once the baseline is established, additional resources (RNs, software, etc.) will be determined. This project will be supported by a Category 1 project, "Implement a Chronic Disease Mgt Registry." Improvement will be marked by reductions, following a PDCA cycle.

Outcome Measures will be as follows:

- **DY4 IT-3.1:** Reduce All unplanned Cause 30 day readmission rate by a TBD % over baseline
- **DY5 IT-3.1:** Reduce All unplanned Cause 30 day readmission rate by a TBD % over baseline.

Population for this project: This population will be the same as that of project 1.3. It will be all patients seen by a defined primary care clinic, diagnosed with a particular chronic disease, derived from the larger population of all patients of Lubbock County (funded, non-funded and under-funded).

Rationale:

Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our Premier Quality Advisor system to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.

Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because UMC experiences thousands of readmissions annually across a broad scope of diagnoses. In comparison to national benchmarks, a significant number of them are expected due to patient acuity. Our goal is to reduce, not eliminate all cause 30 day readmissions. The rationale rests twofold: a) Readmissions are expensive for payers (Medicare) and for the facility (Medicaid, unfunded); and b) Readmissions, if unnecessary are not in the best interest of patient safety. We have seen a reduction in readmissions over the past two years, yet we have room for improvement. Because readmissions generally approach the ER, these also create a patient flow challenge in that environment as well.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	Reducing 30 day all cause readmissions impacts all of the goals of Triple Aim. Patients who do not need readmission are safer outside the acute care facility; Transition Coaches provide patient-centered care (medications, follow up appointments, nutrition assistance, etc.); and avoiding readmissions reduces cost to payers. The infrastructure will be improved, via a "safety net" of care givers (coaches) who are positioned to assist patients, and to avoid unnecessary readmissions. There is a growing body of evidence (as well as experience gained thus far at UMC) substantiating the positive affect of education, coaching and transition assistance from the hospital bed to home, on readmission reduction.	**5**
Addresses Community Need(s)	Per the RHP 12 Needs Assessment, many of the chronic diseases which manifest higher readmission rates are prevalent in our area. Examples: Lubbock BRFSS data indicates 10.7% have diagnosed diabetes. The death rate from diabetes in Lubbock is higher than state average. Incidence of heart disease in Lubbock is 7.1% as compared to a national average of 4%. This project directly addresses the care of chronically ill patients – proactive care, to avoid readmissions. This project is expected to move the dial as each reduced readmission equates to reduced cost and improved health.	**5**
Project Scope/Size	Because this project addresses ALL cause readmission, it is not limited to diagnoses targeted by CMS (AMI, PN and CHF). Thus, the scope will be broad, the resources considerable and the potential impact, large. This project will entail outreach to the community – phone visits, coaching, in-home contacts, and pharmacy intervention.	**5**
Project Investment	The project rests upon a Category 1 project (Disease Registry). In addition to the registry purchase, the project entails human resources (RN coaches). Because this is ALL cause readmission, HR will be the largest component.	**4**

137999206.3.7	**3.IT-3.1**	**All Cause 30-day Readmission Rate**	
University Medical Center		**137999206**	
Related Category 1 or 2 Project(s):	**137999206.2.2**		
Starting Point/Baseline:	**Baseline TBD in DY2**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 P-2: Establish baseline rates **Data Source:** Premier Clinical Advisor Reports **Process Milestone 1 Estimated Incentive Payment:** $288,197	**Process Milestone 2** P-1: Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Documentation of Project planning process. **Process Milestone 2 Estimated Incentive Payment:** $334,057	**Outcome Improvement Target 1:** [IT-3.1]All Cause 30 day readmission rate **Improvement Target:** Reduce All unplanned Cause 30 day readmission rate by a TBD % over baseline **Data Source:** EMR, claims and Premier Clinical Advisor Reports **Estimated Outcome Improvement Target Incentive Payment:** $536,046	**Outcome Improvement Target 2:** [IT-3.1]All Cause 30 day readmission rate **Improvement Target:** Reduce All unplanned Cause 30 day readmission rate by a TBD % over baseline **Data Source:** EMR, claims and Premier Clinical Advisor Reports **Estimated Outcome Improvement Target Incentive Payment:** $1,281,848
DY 2 Estimated Outcome Amount: $288,197	**DY 3 Estimated Outcome Amount:** $334,057	**DY 4 Estimated Outcome Amount:** $536,046	**DY 5 Estimated Outcome Amount:** $1,281,848
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,440,148			

Outcome Measure Title: IT-3.3 Diabetes 30 day readmission rate
Performing Provider: University Medical Center/137999206
RHP Outcome Identification Number: 137999206.3.8
Outcome Domain: OD-3 Potentially Preventable Readmissions – 30 day Readmission Rates

Outcome Measure Description:

Improvement Target: Diabetes 30 day readmission rate [IT-3.3]

- Reduce the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

The process milestones will be as follows:

- **DY-2 – P-2 Establish baseline rates** which will include identifying the target population and the 30-day readmission rate.
- **DY-3 – P-1 Project planning** to determine and then implement strategies and processes to accomplish the pre-discharge medication counseling with a pharmacist and establish any other necessary processes to maintain contact with the patient in order to monitor their understanding of, and compliance with, their medication regimen.

The improvement targets will be as follows:

- **DY-4 – IT-3.3**: Reduce Diabetes 30 day readmission rate by a TBD % from baseline
- **DY-5 – IT-3.3**: Reduce Diabetes 30 day readmission rate by a TBD % from baseline

The population for this project will be all adult (age 18 to 75) diabetic mellitus patients admitted at University Medical Center.

Rationale:

Process Milestones P-2 & P-3 were chosen because they accurately reflect a project in the beginning stage. We will analyze the data from our Premier Quality Advisor system to establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.
Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because Diabetes mellitus is a pervasive disease among the population of patients we serve. Improved understanding of medication

use and closer monitoring of patient compliance should reduce the incidence of morbidities and negative outcomes, including patient readmissions. To date we have no specific information on the size of the adult diabetic population, the understanding of medication use related to diabetes mellitus, or the compliance with a prescribed drug regimen among diabetic adults. In addition, we have not studied the readmission rate for this population of patients. Therefore we would propose collecting and reviewing data during DY-2 to ensure that we understand the size and scope of the problem so that appropriate interventions can be devised and implemented in DY-3. The improvement targets will be established after collecting and reviewing data on the existing conditions. This will allow us to estimate the potential opportunity for improvement more precisely than we would be able to do without having the appropriate data on hand.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals	The incidence of diabetes mellitus has increased tremendously in the US population and is more prominent in minority and poor communities where dietary challenges and access to healthcare contribute incrementally to the overall problem. Numerous studies have shown that improved understanding of drugs and their use in controlling the disease and improving lifestyle and survivability along with ongoing monitoring and contact with healthcare professionals will reduce the negative outcomes associated with this disease. This project will combine the benefits of improved medication knowledge/compliance with access to and monitoring by a healthcare professional in an effort to reduce diabetic readmissions to the hospital. Other projects that will likely impact this one include: Expanded Primary Care Capacity and Enhance Urgent Medical Advice (call center).	**5**
Addresses Community Need(s)	The following paragraph is taken directly from the Community Needs Assessment: Diabetes Mellitus – Patients on survey who were told they have diabetes in 2010 (9.1%) and 2007 (11.0%) are compared to nationwide in 2009 (8.3%) and Texas 2007 (9.3%). Statistically there are many more cases of undiagnosed diabetes. Survey respondents indicated that 8.7 were told they had borderline diabetes and 4.3% of women said diabetes was diagnosed when they were pregnant. All national surveys show the incidence of diabetes is increasing. Approximately 1.8 million adult Texans have Type 2 diabetes and 460,000 are undiagnosed. Diabetes related illness is the 6th leading cause of death in Texas and the 4th leading cause of death for African Americans and Hispanics. Approximately 21.9% of adults with diagnosed diabetes do not have health insurance. Lubbock BRFSS data indicate that 10.7 percent have diagnosed diabetes. The death rate from diabetes in Lubbock is 38.6/100,000 and is higher that the Texas rate of 26.5/100,000. Specific severe and urgent community needs that the project could impact include: CN.1 Severe primary care provider shortage, wait time, expense, access to care CN.2 Inability to get an appointment, lack of insurance, need to use ERs for initial contact. CN.3 Poor insurance support or uninsured.	**5**

	CN.4 High incidence of obesity, diabetes mellitus and heart disease. CN.5 Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease	
Project Scope/Size	It is estimated that approximately 10% of the populations suffers from diabetes mellitus. This results in a large number of hospitalizations, amputations, kidney failure, heart disease, infections, and mortality. This project will reduce the number of diabetic hospitalizations by improving medication knowledge and compliance and providing better access to healthcare providers. UMC will hire additional pharmacist staff to make contact with patients prior to discharge and then follow up regularly to monitor compliance and complications and make recommendations for primary physician contact if necessary to avoid situations from developing to the point of requiring hospitalization. Potential savings are significant, especially in the long-term, when one considers the cost of dialysis, renal transplant, sepsis, and other very serious complications of diabetes.	**4**
Project Investment	The major investment in implementing this project consists of hiring pharmacists and support staff to carry out this new function and monitor the results. The exact number of staff will be determined after data collection is accomplished and the number of patients to be followed is known.	**3**

137999206.3.8	3.IT-3.3	Diabetes 30-day Readmission Rate	
University Medical Center		137999206	
Related Category 1 or 2 Project(s):	137999206.2.3		
Starting Point/Baseline:	Baseline TBD in DY2		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	*DY 5 (10/1/2015- 9/30/2015)*
Process Milestone 1 **P-2:** Establish baseline rates **Data Source:** Premier Clinical Advisor Reports **Process Milestone 1 Estimated Incentive Payment:** $257,860	**Process Milestone 2** **P-1:** Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Documentation of Project planning process. **Process Milestone 2 Estimated Incentive Payment:** $298,894	**Outcome Improvement Target 1:** [IT-3.3]Diabetes 30 day readmission rate **Improvement Target:** Reduce Diabetes 30 day readmission rate by a TBD % from baseline **Data Source:** EMR, claims & Premier Clinical Advisor Reports **Estimated Outcome Improvement Target Incentive Payment:** $479,620	**Outcome Improvement Target 2:** [IT-3.3]Diabetes 30 day readmission rate **Improvement Target:** Reduce Diabetes 30 day readmission rate by a TBD % from baseline **Data Source:** EMR, claims & Premier Clinical Advisor Reports **Estimated Outcome Improvement Target Incentive Payment:** $1,146,917
DY 2 Estimated Outcome Amount: $257,860	**DY 3 Estimated Outcome Amount**: $298,894	**DY 4 Estimated Outcome Amount**: $479,620	**DY 5 Estimated Outcome Amount**: $1,146,917
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,183,291			

Outcome Measure Title: IT-13.3 Proportion with more than one emergency room visit in the last days of life

Performing Provider: University Medical Center/137999206

RHP Outcome Identification Number: 137999206.3.9 – "PASS 2"

- **Improvement Target:** IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211 *(Standalone measure)*

- **Outcome Measure Description:** Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.

  Process Milestones will be as follows:
  - DY2 - P-3.2: Establish baseline rates: Baseline rates will be established via EMR for the identified population.
  - DY3 - P-3.1: Project planning: Stakeholders to be engaged will include medical providers including physicians, nurses, case management and other providers.

  Outcome Domains:
  - DY4 – IT-13.3 Reduce the Proportion with more than one emergency room visit in the last days of life by a TBD % (NQF 0211) ***(****Standalone measure)*- Improvement targets will be set once baseline rates are established.
  - DY5 **-** IT-13.3 Reduce the Proportion with more than one emergency room visit in the last days of life by a TBD % (NQF 0211) ***(****Standalone measure)*- Improvement targets will be set once baseline rates are established.

  Population for this project: The population for this project will be chronically and severely ill patients that are seen by the palliative care team in University Medical Center.

  Rationale:
  Process Milestones – P-1 & P-2 were chosen because they accurately reflect a project in the beginning stage. We will establish a baseline and determine our improvement achievement targets in DY2. Then we will develop a plan to achieve those targets in DY3.
  Improvement targets for our outcome measure are TBD in DY2 but the reason we selected this outcome measure is because Palliative care has long been recognized to meet patient expectations and improve quality but intuitively its proper use should also lower costs. One area of relatively higher cost is care provided in the emergency center. We seek to measure the impact of our palliative care intervention on reducing such high cost emergency room care. If patients are enrolled into a hospice program through the efforts of the palliative care program then utilization in the emergency center should be

markedly less. Therefore, this intervention should lower cost, improve patient satisfaction, and enhance quality. To track improvements in cost savings we will utilize claims data. To track patient satisfaction outcomes, we will use data from the patient satisfaction survey. For assessment of quality outcomes, we will utilize both claims data and data from the electronic health records.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	This palliative care intervention greatly helps to further the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. Most patients prefer to die at home however most patients die in the hospital because they did not have access to high quality palliative care programs. This project will serve the Medicaid and uninsured residents of our county since the operation will be within the county hospital where a majority of these patients seek their care. Palliative care will serve as a liaison with medical staff in transitioning patients into cost effective hospice systems. Numerous studies have shown that Palliative care will Improve outcomes while containing cost growth by reducing unnecessary admissions and readmissions.	**4**
Addresses Community Need(s)	Our community needs patient centered care at the end of life. Currently there is limited access to high quality palliative care with certain sub-populations. Within the county hospital patients who have Medicaid or underinsurance are frequently faced with critical illness or end of life issues. As this facility serves as the safety net hospital for the region it is critical that high quality palliative care programs exist to meet this need.	**2**
Project Scope/Size	In the end everyone faces death and it is critical that patients receive high quality end of life care. This is true regardless of the economic class or ethnic background. While death is ubiquitous each person is unique. It is critical that each persons end of life care is centered on their unique needs. In this way the various cultures and ethnic groups can receive culturally appropriate care at such an important time as critical illness and end of life.	**3**
Project Investment	The major capital needed to deliver high quality care is the time of the professionals who will be working with the patients and their families to deliver this care. As might be expected this can be considerable as families grapple with the very difficult decisions regarding their loved ones. Palliative medicine is a multi-disciplinary field and practitioners from across medicine will have to be engaged. From social workers to chaplains to nurse managers to physicians all are integral to an effective team.Another important need for excellent care is the need to create a strong culture across the health system to support palliative care. This requires education and active programing. These systems will require development and on-going maintenance.	**3**

137999206.3.9 – "PASS 2"	Outcome Measure IT-13.3	Proportion with more than one emergency room visit in the last days of life	
University Medical Center		**137999206**	
Related Category 1 or 2 Project(s):	**137999206.2.4**		
Starting Point/Baseline: To be determined	**Baseline info: Baseline amounts will be determined during DY2**		
DY 2 (10/1/2012-9/30/2013)	*DY 3 (10/1/2013-9/30/2014)*	*DY 4 (10/1/2014-9/30/2015)*	
Process Milestone 1: P-3.2 Establish baseline **Data Source:** EHR, Claims **Process Milestone 1 Estimated Incentive Payment:** $259,915	**Process Milestone 2: P-3.1** Establish a plan **Data Source:** Documentation of the plan **Estimated Milestone 2 Incentive Payment:** $288,408	**Outcome Improvement Target 1:** IT-13.3 Proportion with more than one emergency visit in the last days of life **Improvement Target:** Reduce the Proportion with more than one emergency room visit in the last days of life by a TBD % **Data Source:** EHR, Claims **Estimated Outcome Improvement Target 1 Incentive Payment:** $440,410	**Outcome Improvement Target 2:** IT-13.3 Proportion with more than one emergency visit in the last days of life **Improvement Target:** Reduce the Proportion with more than one emergency room visit in the last days of life by a TBD % **Data Source:** EHR, Claims **Estimated Outcome Improvement Target 2 Incentive Payment:** $1,012,530
DY 2 Estimated Outcome Amount: **$259,915**	**DY 3 Estimated Outcome Amount:** **$ 288,408**	**DY 4 Estimated Outcome Amount** **$440,410**	**DY 5 Estimated Outcome Amount:** **$1,012,530**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$2,001,264*			

Outcome Measure Title: IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores
Project Title: West Texas Center RHP 12 Telemedicine Expansion
Performing Provider: West Texas Center /130725806
RHP Outcome Identification Number: 130725806.3.1
Outcome Domain: OD-6 -Patient Satisfaction

Outcome Measure Description: West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected improvement target IT-6-1(pg 398 of protocol): Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.
Our Center will additionally be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.
Process milestones:
West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems being selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures.
Relationship to other Projects: West Texas Centers is also proposing Project Number 130725806.1.2expansion of WTC mobile crisis outreach staff and a RHP 12 Dawson County behavioral health and primary care integration project number 130725806.2.1.

Outcome Improvement Targets for each year: West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. During DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.

Rationale: All West Texas Center counties in RHP 12 are designated Health Professional Shortage Areas (HPSAs), with a very rural population. The closest major medical center or any behavioral health care other than West Texas Centers is forty to seventy miles. West Texas Centers is the only provider of behavioral health services in the county. Without telemedicine it would not be possible to provide the psychiatric services which are currently being provided. Current capacity however; does not meet the demands of the rural area. This expansion of telemedicine will enable West Texas Centers to increase access to services via the increase in capacity achieved through further broadband connectivity and acquisition of newer, more advanced telecommunication connections and software. These milestones will indicate all telemedicine upgrades and provider recruitment activities have prepared the service sites to being patient satisfaction related outcome analysis. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Process Category 3 Milestones were selected to develop baseline data to identify, support and achieve the improvement targets of DY 4 and 5.

Criteria	Narrative	Score
Achieves Waiver Goals	Valuations were allocated by percentage of Category 1 valuation allocations. Consideration was given to current crisis response times in the project Counties, county patient satisfaction with current telemedicine technology/services, availability of other behavioral health providers and length of waiting time for psychiatric services in the project locations. RHP 12 goals include seeking to transform health care by bending the cost curve. This project should support this goal in that it will increase WTC capacity to provide diversionary services for clients from higher cost forms of treatment such as hospitals and jails. The regional goals also include transforming health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time treatment. This project will accomplish those goals through increased access to care in very rural areas, where resources such as transportation and physician time are extremely scarce.	5
Addresses Community Need(s)	Currently counties served by this project have limited access to psychiatrist time through the current telemedicine system. This project will increase that time to add approximately ten hours per week aggregate to physician coverage in these counties. These counties area gradually losing population due to their rural nature and the cost associated with living in the rural area, therefore this project will meet the community needs as described in the assessment; however it is anticipated as the population decreases the need for behavioral health services typically increases. The overall project will increase access to behavioral health care services in these locations by 15% over current capacity by the end of demonstration year 5. This project relates to RHP 12 goals of improving overall healthcare access in the region by expanding access to behavioral health care services	3
Project Scope/Size	As Improvement Targets are to be determined valuations were allocated by percentage of Category 1 valuation allocations. Project is of medium size due to this being an expansion of current telemedicine networks. West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. During DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.	3
Project Investment	Project will require significant purchase of costly equipment, relatively short implementation timeframes and minimum risk. Improvement milestones should be achieved within established schedules. West Texas Centers other project in the region is a primary and behavioral health care integration with significantly higher risk, costs and human resource requirements than this project.	2

130725806.3.1	3.IT.6. 1	IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers		130725806	
Related Category 1 or 2 Projects	130725806.1.1		
Starting Point/Baseline	Establishment of Outcome Improvement Targets Pending Further CMS Guidance		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 **P-1**(Cat 3, pg 363) Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Meeting sign in sheets; procurement documents; Network provider meetings; public forums. Process Milestone 1 P-1 Estimated Incentive Payment*:* $0	**Milestone 2** **P-3(Cat 3 pg 363)** Develop and test data systems Data Source: Provider feedback, customer satisfaction surveys and computer based training documents. Baseline: Currently there is no co-location arrangement between West Texas Centers and a primary care provider/facility therefore baseline for this milestone is N/A Process Milestone P-3 Estimated Incentive Payment*:* $34,784	Outcome Improvement Target 1 Outcome Improvement Target(IT 6.1-1Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Data Source: It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: patients	Outcome Improvement Target 2: Outcome Improvement Target(IT 6.1-1Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Data Source: It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. Outcome Improvement Target 3 Estimated Incentive Payment*:* $80,894

		are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. Outcome Improvement Target 1 Estimated Incentive Payment: $37,211	
Year 2 Estimated Outcome Amount: $.0.00	Year 3 Estimated Outcome Amount: $34,784	Year 4 Estimated Outcome Amount: $37,211	Year 5 Estimated Outcome Amount: $80,894
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $152,889			

Outcome Measure Title: IT-6.1 Percent Improvement over baseline of patient satisfaction scores (standalone measure)
Project Title: West Texas Centers Dawson County Behavioral and Primary Care Integration Project
Performing Provider: West Texas Centers/130725806
Unique RHP Outcome ID: 130725806.3.2
Outcome Domain: OD-6 Patient Satisfaction

Outcome Measure Description: West Texas Centers has selected outcome measure OD-6(pg 398) Patient Satisfaction. Process milestone P-1(Cat 3 pg 363): Project planning - engage stakeholders, identify current capacity and needed resources was selected for DY 2. Milestone P-3(Cat 3 pg 363): Develop and test data systems was the process milestone selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. DY 4 and 5 improvement targets selected were: IT-6-1(Cat 3 pg 398): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) (Cat 3 pg 398) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This would equate to 34 persons indicating improved patient satisfaction due to the integrated service provision. Subsequently in DY 5 this expectation was increased to 40% or 55 persons indicating improved patient satisfaction due to the integration of services. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.
Our Center will additionally be working with other Community Centers in learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.
Outcome Improvement Target(s) for each year: DY DY 4 and 5 improvement targets selected were: IT-6-1(Cat 3 pg 398): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) (Cat 3 pg 398) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This would equate to 34 persons indicating improved patient satisfaction due to the integrated service provision. Subsequently in DY 5 this expectation was increased to 40% or 55 persons indicating improved patient satisfaction due to the integration of services. **Rationale:** This project represents a new initiative for West Texas Centers as well as the RHP. Dawson County currently has providers in separate facilities with only limited interaction. Process measures were selected to define

a baseline for quality improvement targets. Patient satisfaction surveys are designed to produce comparable data on the patients' perspectives of care that allows for objective and meaningful comparisons between institutions on domains that are important to individuals. Public reporting and sharing of survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for the public investment. A recent study reported the association between patient satisfaction and mortality rates after adjusting for clinical quality. Higher patient satisfaction was associated with lower mortality even after controlling for adherence to evidence-based practice guidelines, demonstrating that patients can judge the quality of clinical care they receive. Patient satisfaction is not about making patients "happy". It is about improving the patients experience to facilitate health and medical outcomes. When patients are satisfied, trust is enhanced. When patients trust their physician, they are more likely to disclose information, follow advice and adhere to treatment plans. Improving patient satisfaction also helps to ensure that people don't avoid getting the care they need which could prevent larger health issues in the future. (Press Ganey, "How Patient Satisfaction Correlates with Clinical Quality" by Maxwell Drain, MA, April 12, 2010). As West Texas Centers is not currently conducting integrated service delivery with primary care, data systems, consumer satisfaction instruments (expected to be the CAHPS or ECHO survey instruments) and other methods of data collection for this project will have to be reviewed, revised or developed during DY 2 and 3 in order to identify and achieve improvement targets for DY 4 and 5. Process milestones were selected to facilitate identifying appropriate data sources for surveying and gathering patient satisfaction data. Since West Texas Centers does not currently operate a primary and behavioral health integrated service site, all process milestones were chosen in consideration of the lack of accurate reports and resources currently available to measure and monitor potential improvement targets for an integration project.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	West Texas Centers considered several factors in valuing this project, including, reduction in cost associated with emergency room visits and hospitalizations for primary care and behavioral health care. Research supports and West Texas Center expects this project will improve the physical health of the behavioral health consumer through a higher degree of access to primary care, decreased emergency room visits and hospitalizations'. An additional valuation factor used for this project is the research associated with identifying a monetary value for a collaborative primary/behavioral health intervention which is measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Substantive research supports the quality of life improvement of integrated services, particularly for the behavioral health consumer. Improvement measures were selected to effectively determine if patients in the new integrated care environment are receiving services more holistically focused to achieve easier access to both behavioral healthcare and primary care, but also to insure services are improving "whole body" outcomes. Desired outcomes include both improved patient experience and the cost effectiveness of integrated treatment. Additional sources for valuation consideration used included economic evaluation models and extensive literature reviews which were conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.	N/A
Addresses Community Need(s)	This project addresses RHP 12 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lock of insurance, need to use ERs for initial contact will be specifically addressed through this project. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking g and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied. The integration of behavioral health and primary care logically improve the opportunities to better meet the needs of the consumer while lowering costs through economies of scale all off which are RHP goals and were identified in the community needs assessment. Integrated model will also demonstrate a progressive, evidenced based approach to health care essential to the recruitment and retention of highly qualified professionals, particularly in rural communities. The importance of this project to the local community in Dawson County cannot be overstated.	N/A
Project Scope/Size	Current WTC patient census in Dawson county is averaging 138 unduplicated persons annually. It is expected the full WTC patient population will be served from the integrated site. Approximately fifteen to twenty WTC staff will house full time in the facility or use the facility for provision of telemedicine or other types of itinerant services. This is a new concept for WTC and will require extensive planning and implementation activities. Since WTC does not currently operate any integrated care facility nor does Dawson County have other behavioral health providers, this project will be both innovative for WTC as well as the Dawson County community. This project will be an extremely high priority for WTC as it's success will be a milestone for the region as a whole and will potentially become the "model" for further integration projects for WTC in other areas as well as other providers within the RHP.	N/A

Project Investment	This project is West Texas Center's largest and most costly project among three of the four regional health service areas in which WTC serves counties. It is targeted to reach a minimum of 100% of the consumers we serve in the county This project will involve recruitment and training of an additional psychiatrist (.25 FTE), a .25 FTE registered nurse and at least 2 additional full time support staff. This project involves lease procurement and negotiations, legal consultation and potential renovation of the site. This project is the first of its' kind for the Center therefore elevated risk are expected. Implementation timeframes will be highly dependent upon facility readiness. Additional costs related to relocation of WTC's current clinic operations including telecommunication equipment, files, furniture are expected to be substantial considering the current "glut" of manpower in the area.	N/A

An additional valuation factor used for this project is the research associated with identifying a monetary value for a collaborative primary/behavioral health intervention which is measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Substantive research supports the quality of life improvement of integrated services, particularly for the behavioral health consumer.

130725806.3.2	IT-6.1	IT-6.1 Percent Improvement over baseline of patient satisfaction scores	
West Texas Centers			130725806
Related Category 1 or 2 Projects:	130725806.2.1		
Starting Point/Baseline:	DY3 satisfaction survey		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: **P-1(Cat 3 pg 363)** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline: Currently there is no co-location arrangement between West Texas Centers and a primary care provider/facility therefore baseline for this milestone is N/A Data Source: Community forums; minutes from hospital/WTC collaborations; architectural designs; lease agreements. Process Milestone P-1 Estimated Incentive Payment*:* $0	**Milestone 2** **P-3(Cat 3 pg 363)** Develop and test data systems Data Source: system testing; hospital collaboration meeting minutes; procurement documents; final lease agreements; space design plans; customer satisfaction surveys. Baseline: Currently there is no co-location arrangement between West Texas Centers and a primary care provider/facility therefore baseline for this milestone is N/A Process Milestone P-3 Estimated Incentive Payment*:* $ 46,720	Outcome Improvement Target 1: Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1)25% Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Improvement Target: 25% improvement over baseline of patient satisfaction scores related to the standalone measure: patients are getting timely care, appointments, and information. This would equate to 34 persons indicating improved patient satisfaction due to the integrated service provision. Data Source/baseline: DY 3 Patient Satisfaction Surveys to establish the baseline. Will use the CAHPS or the ECHO survey instrument.	Outcome Improvement Target 2: Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1)50% Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Improvement Target: 40% improvement over baseline of patient satisfaction scores related to the standalone measure: patients are getting timely care, appointments, and information. This would equate to 55 persons indicating improved patient satisfaction due to the integrated service provision. Data Source/baseline: DY 3 Patient Satisfaction Surveys to establish the baseline .Will use the CAHPS or the ECHO survey instrument. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $108,651

		Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 24,989.50	
Year 2 Estimated Outcome Amount: 0.00	**Year 3 Estimated Outcome Amount:** $46,720	**Year 4 Estimated Outcome Amount:** $49,979	**Year 5 Estimated Outcome Amount:** $108,651
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $205,350			

Outcome Measure Title: OD-6: Patient Satisfaction; 130725806.3.3; IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (standalone measure)
Performing Provider: West Texas Center /130725806
RHP Outcome Identification Number: 130725806.3.3 – **"PASS 2"**
Outcome Domain: OD-9: Right Care, Right Setting

Outcome Measure Description: The process milestone selected for DY 2 was:

P-1(Cat 3 pg 363): Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Process measure P-4(Cat 3 pg 363): Conduct Plan Do Study Act (PDSA) cycle to improve data collection and intervention activities was selected for DY 3.

The planning component will be the primary emphasis for WTC during DY 2 for this project as well as WTC project numbers 130725806.2.1 and 130725806.1.1. This project is expected to serve roughly 45% Medicaid and 54% uninsured with the remaining percentage of patients having some form of third party insurance; however, because we are the public safety net for behavioral health, the target population for this project would include any person in the WTC service area experiencing a psychiatric emergency and accessing the WTC crisis hotline. Inappropriate incarceration of persons experiencing a mental health crisis is detrimental for the patient and law enforcement, but is rapidly becoming the norm unfortunately as behavioral health crisis services are so limited in the rural area. Due to extremely limited hospital capacity for psychiatric emergencies, WTC continually works to provide appropriate diversions from hospitalization. Additionally, WTC works closely with all law enforcement and the court systems throughout the region to address the issue of persons who may have committed minor misdemeanor offenses but have been unable to access crisis personnel in time to avoid the arrest, thus filling jails to capacity and soaking up precious time and resources from our area law enforcement and legal systems.
For these reasons WTC has selected for demonstration years 3-5:
Improvement Target IT-9.1(standalone measure): Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (standalone measure). Baseline for these targets will be related to diversion and incarceration data from WTC FY 2012, gap analysis data from DY 2 and information obtained from PDSA cycles, gap analysis in DY 3.
Improvement Targets for DY 4 and DY 5 will be:

- DY4-IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population

- DY5-IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population.

Rationale: All West Texas Center counties in RHP 12 are designated Health Professional Shortage Areas (HPSAs), with a very rural population. In FY 2012 West Texas Centers received over 800 crisis calls for the RHP 12 West Texas Center counties with over 500 being legitimate "go mobile" response situations. The current Mobile Crisis Outreach team is responding to calls throughout the very rural and vast coverage area of the West Texas RHP 12 counties. Additional assessment of the West Texas Centers crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. Milestones including the gap analysis will enable the provider to insure real time assessment and corrections are occurring. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. West Texas Centers currently provides these crisis services with only one Mobile Crisis Outreach staff member in the RHP 12 service area. This one person is responsible responding to the crisis call within one hour of notification one a 24/7 call rotation. With an additional Mobile Crisis Outreach staff it is expected that we would be able to reduce our crisis response time and intervene in behavioral health crisis prior to the consumer being booked into the jail, admitted to the ER or taken to a psychiatric hospital for admission.

- **Valuation**

Criteria	Narrative	Score
Achieves Waiver Goals	The goal of this project is to decrease inappropriate incarcerations and psychiatric admissions to emergency departments. Consideration was given to current crisis response times in the project Counties, county patient satisfaction with current crisis services. This project can meet all of the Triple Aim goals of the region through diversion of the patient to the most appropriate treatment setting, improving quality of life for the patient all while providing the services needed in the lowest, most cost effective treatment.	5

Addresses Community Need(s)	As Improvement Targets are to be determined valuations were allocated by percentage of Category 1 valuation allocations. Outcome evaluation consideration included West Texas Center's current crisis system costs and estimated costs of achieving all project goals. This project addresses RHP 12 Rural Community Needs Assessment number CN.2; severe lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact will be specifically addressed through this project. This project will help meet this need in relation the use of ERs, prisons and jails for initial patient contact as well as the overall lack of mental health services in this extremely rural area of the region.	3
Project Scope/Size	This project expands the current Mobile Crisis Outreach staff to effectively double capacity for providing crisis services in the WTC area of the RHP. Because this project is the expansion of existing capacity, it is considered a medium size project for WTC. This project will however; provide additional capacity to 7 very rural counties within the RHP and has the capacity to have significant cost saving impact through diversions of consumers from inappropriate admissions to emergency departments, jails and prisons. As Improvement Targets are to be determined valuations were allocated by percentage of Category 1 valuation allocations. Project is of medium size due to this being an expansion of current the current crisis network.	3
Project Investment	As Improvement Targets are to be determined valuations were allocated by percentage of Category 1 valuation allocations. This project will require the hiring of an addition Mobile Crisis Outreach staff to include salary and benefits. It will also require additional support and availability of psychiatrists, RN's as well as transportation costs to access the crisis location and hardware/software purchases to enable the EMR functionality at the crisis location.	2

130725806.3.3	3. IT.9-1	IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons(standalone measure)	
West Texas Centers		130725806	
Related Category 1 or 2 Projects		130725806.1.2	
Starting Point/Baseline	Baseline TBD during DY 2		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1: P-1: Project planning: engage	Process Milestone 2: P-4:	**Outcome Improvement Target 1:** IT-9.1(Cat 3 pg, 405)	**Outcome Improvement Target 2** IT-9.1(Cat 3 pg, 405)

stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of Project planning process. Process Milestone 2 Estimated Incentive Payment: 0	Conduct Plan Do Study Act(PDSA) cycles to improve data collection and intervention activities Data Source: Documentation of PDSA processes. Process Milestone 2 Estimated Incentive Payment: $12,427.00	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population (standalone measure) Baseline: Data will be obtained through DSHS encounter data; local law enforcement officials, WTC hotline data and WTC patient records during DY 3 to establish baseline. Outcome: WTC will determine a percentage of baseline decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons in DY 3. Outcome Improvement Target 1 Estimated Incentive Payment: $12,651.00	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons by a TBD% of the baseline for the targeted population (standalone measure) Baseline: Data will be obtained through DSHS encounter data; local law enforcement officials, WTC hotline data and WTC patient records during DY 3 to establish baseline. Outcome: WTC will determine a percentage of baseline decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons in DY 3. Outcome Improvement Target 3 Estimated Incentive Payment: $26,442.00
Year 2 Estimated Outcome Amount: $.0.00	Year 3 Estimated Outcome Amount: $12,427.00	Year 4 Estimated Outcome Amount: $12,651.00	Year 5 Estimated Outcome Amount: $26,442.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $51,521.00			

Outcome Measure Title: IT-3.3 Diabetes 30 Day Readmission Rate

Performing Provider: Yoakum County Hospital/137227806

RHP Outcome Identification Number: 137227806.3.1

Outcome Domain: OD – 3 potentially preventable readmission – 30 day readmission rates

Outcome Measure Description:

IT-3.3 - Diabetes 30 Day Readmission

- Reduce the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission

Process Milestones:

- **DY2**
  - P-2 – Establish baseline rates.
- **DY3**
  - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plans.

Outcome Improvement Target(s) for each year:

- **DY4**
  - IT-3.3 Reduce diabetes 30 day Readmission by a TBD %
- **DY5**
  - IT-3.3 Reduce diabetes 30 day Readmission by a TBD %

Improvement targets will not be determined until there is more time to study appropriate outcome improvement targets in DY3.

- **Rationale:** Yoakum County Hospital must establish a solid baseline in DY2 and DY3 by utilization of the hospital electronic health record to ensure that YCH can "move the dial" forward for DY4 & DY5. In DY3, the hospital will engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation of plans. A good plan in DY 3 will facilitate progress in "moving the dial" in DY4 and DY5.
  The main reason for selecting OD-3 Diabetes PPR is that diabetes has so many comorbidities associated with the chronic disease. Using potentially preventable readmissions will ensure that we are exploring the link between diabetic educations, self-management techniques, and keeping hemoglobin A1C within control. It is also a measure of quality at a hospital. Improvement targets will not be determined until there is more time to study appropriate outcome improvement targets in DY3.
  - **Process Milestones:** In DY 2, process milestone P-2: Establish baseline rates for diabetic Medicaid potentially preventable readmission rates. Data Source: Yoakum County Hospital electronic health record Paragon. Baseline rates will be determined by March 1, 2013. In DY3, milestone P-1 project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plans. Data source: EHR and documentation of plan.
  - **Improvement Target Achievement levels:** IT 3.3 Diabetes 30 day readmission rate for type 1 & type 2 diabetes that are Medicaid patients improvement targets is TBD in DY2 based on the timeframe in which the intervention will occur

and expectations based on research of similar interventions for what is achievable during the start-up period. These outcome measures being addressed are largely affected by social determinants other than by this projects encounter (i.e. transportation or behavioral issues, etc.).

- **Other Improvement Target:** The improvement target - IT-3.3 Diabetes 30 day readmission rate (Standalone measure) Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Denominator: : The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

  Outcome improvement targets are TBD.

Related Category 1 or 2 Projects: 137227806.2.1 is the unique project ID from category 2 that relates to category 3. The category 2 project is 2.6 and the project option is 2.6.2.

Outcome Measure Valuation: Our region used a project scoring system based on the following criteria:

Criteria	Narrative	Score
Achieves Waiver Goals	This project will reach out to Medicaid diabetics in particular by reviewing potentially preventable readmissions within 30 days. This will help reduce costs at Yoakum County Hospital. The expected impact would be to improve quality to Yoakum County residents by focusing on self-management techniques and coaching diabetics on foot care, retinal screenings, keeping hemoglobin A1c levels within control, etc. There is strong evidence that diabetes is one of the most costly chronic diseases in the United States. With greater coordination of care between YCH mid-level providers and physicians, diabetics will be given many tools to improve their health and maintain a healthier lifestyle.	**4**

Addresses Community Need(s)	This project meets community need 5 on the RHP Region 12 Community Needs Assessment (CN.5 - Need for specialists to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease - BRFSS data source). According to the 2012 County Health Rankings and Roadmaps, "30% of Yoakum County community members are obese (BMI greater than or equal to 30), 30% of the county is uninsured, 44% of restaurants are fast food, and 21% of children live in poverty. 8.5% of Yoakum County is diabetic and known for having challenges with medication compliance, eating healthy meals, and daily exercise." This project is related to several chronic conditions and addresses many other community needs by potentially reducing comorbidities associated with diabetes and possibly reversing type 2 diabetes in certain patients.	**5**
Project Scope/Size	This project is large relative to other community education that Yoakum County Hospital is currently committed to. This will be a large project for mid-levels and physicians because of the new workflow, various forms, and system redesign. There should eventually be savings from this program related to decreased potentially preventable readmissions and admissions related to diabetes if hemoglobin A1c levels are within better control.	**4**
Project Investment	The time to implement this program will be significant and will fall high on the priority list compared to many other organizational priorities (i.e. IT system additional purchases for the ER and physician documentation). In addition to a new wellness facility in the central Yoakum county area and revamping/redesigning the current wellness facility in Denver City, this program will require the recruitment and training of the health promotion and disease prevention program team (i.e. the Wellness Team). This team will have an innovative and unique skill set requiring "tech savvy," medically knowledgeable individuals with exemplary people skills including but not limited to a Wellness Program Director, Diabetic Educator, Mental Health Professional, and Wellness Assistants. Tracking PPRs will be challenging to staff members and require significant training.	**2**

137227806.3.1	*3.IT-3.3*	Diabetes 30 day readmission rate	
Yoakum County Hospital			*137227806*
Related Category 1 or 2 Projects:	*137227806.2.1*		
Starting Point/Baseline:	*To be Determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2 Establish baseline rates **Data Source:** E.H.R. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $37,005	**Process Milestone 2 P-1** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implantation of plans **Data Source:** Documentation of plan and E.H.R. **Process Milestone 2 Estimated Incentive Payment:** $42,894	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30 day readmission rate **Improvement Target:** Reduce Diabetic readmissions by a % TBD **Data Source:** E.H.R. **Outcome Improvement Target 1 Estimated Incentive Payment:** $68,829	**Outcome Improvement Target 3** [IT-3.3]: Diabetes 30 day readmission rate **Improvement Target:** Reduce Diabetic readmissions by a % TBD **Data Source:** E.H.R. **Outcome Improvement Target 3 Estimated Incentive Payment:** $164,592
Year 2 Estimated Outcome Amount: $37,005	**Year 3 Estimated Outcome Amount:** $42,894	**Year 4 Estimated Outcome Amount:** $68,829	**Year 5 Estimated Outcome Amount:** $164,592
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $313,320			

Project Title: IT-6.1- Percent improvement over baseline of patient satisfaction scores
Performing Provider: Yoakum County Hospital/137227806
RHP Outcome Identification Number: 137227806.3.3 – "PASS 3b"

- **Outcome Domain: Patient Satisfaction**
- **Domain Number: OD-6**
- **Improvement Target: Percent improvement over baseline of patient satisfaction scores-IT-6.1**
- **Unique Outcome ID: 137227806.3.3**

- **Outcome Measure Description:** Yoakum County Hospital the outcome measure 6.1-percent improvement over baseline of patient satisfaction scores. For DY2, Yoakum County Hospital (YCH) will perform P-1 Project Planning. The project planning process will consist of the following: 1) Identify vendors for CGCAHPS. 2) Choose Vendor for CGCAHPS. 3) Sign contract with CGCAHPS vendor. 4) Implement CGCAHPS patient satisfaction surveys. 5) Develop a CGCAHPS baseline score for West Texas Medical Center and the Plains Clinic. 6) Identify the top five opportunities for improvement related to patient satisfaction.

  In DY3, YCH will establish baseline patient satisfaction scores by surveying our target population of new and established psychology and psychiatry specialist visits at the Plains Clinic and West Texas Medical Center (the two RHC's that YCH owns). Improvement targets will be TBD in DY2. In DY 4, YCH will identify the top five opportunities for improvement related to patient satisfaction. In DY5, YCH will improve patient satisfaction scores within our target population new and established psychology and psychiatry specialist visits at the Plains Clinic and West Texas Medical Center TBD through the use of telemedicine.

  Rationale: YCH chose these process milestones because this is a new project. The planning stages take place in DY2 and we will establish a baseline in DY3. Outcome improvement targets will be determined in DY2 for implementation in DY3. Our improvement milestone for the waiver is (I-12) is to increase the number of telemedicine visits for our target population by 15% over baseline in DY5. This plan is related to the Region 12 Community Needs Assessment CN.2 - Lack of mental health services, inability to get an appointment, lack of insurance, and need to use ERs for initial contact – source: BRFSS data, survey, focus groups, DSHS data. This is considered a critical need by the Region 12 Community Needs Assessment.
  In June 2011, studies indicated that nearly 80 million Americans live in a mental health professional shortage area (U.S. Health and Human Services Health Resources and Services Administration), and research shows telemedicine and telehealth

in particular would greatly address several hurdles to securing mental health services. YCH chose to patient satisfaction through the use of telemedicine because our main goal is to increase access to psychology and psychiatric mental health needs. Our target population is Medicaid/Medicare/commercial insurance patients who need to see a psychologist or psychiatrist. With a baseline of zero to start, the plan is to increase to 20% over baseline in DY5 for our targeted population. This will be a brand new project for YCH and will require significant education in the primary and secondary YCH service areas. YCH expects this to be more challenging with the Medicare population.

- **Project Valuation:**

Criteria	Narrative	Score
Achieves Waiver Goals	This project promotes high-quality and patient centered care in the most cost effective way. It achieves all of the four stated waiver goals. Telemedicine will have a positive impact on Medicaid/Medicare/commercial insurance residents within the primary and secondary service areas at Yoakum County Hospital who typically travel great distances to seek specialty care. Telemedicine shows great potential to achieve a triple aim.	**5**
Addresses Community Need(s)	Yoakum County Hospital valued this project at a 4 because it meets the local physician needs and regional needs. Increased access to mental/behavioral health is a top need in Yoakum County and the region. Medicaid/Medicare/commercial insurance patients will not have to travel such long distances to see their physician. This should increase access and specialty care options by partnering with Texas Tech Health Sciences Center, increase customer satisfaction, and reduce travel expenses for patients.	**4**
Project Scope/Size	Telemedicine will serve western Texas and eastern New Mexico within 45 miles of Denver City. This project will expand patient choice and provide more specialties to Yoakum County and beyond. Increased telemedicine visits will yield better access for mental health patients and counseling resources. This will decrease expenses for patients and promote better medication management for psychiatric care.	**4**
Project Investment	Yoakum County Hospital will need to invest in patient satisfaction decision support information technology and telemedicine equipment for two Rural Health Clinics. This project should be cost-efficient and impact the primary and secondary service areas at Yoakum County Hospital. The introduction of telemedicine to Yoakum County and beyond will “move the dial” in the right direction.	**3**

137227806.3.3 – "PASS 3b"	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Yoakum County Hospital		**137227806**	
Related Category 1 or 2 Project:	**137227806.1.2**		
Starting Point/Baseline: 0%	**Yoakum County Hospital will sample patients in our target population of new and established Medicaid/Medicare/commercial insurance patients prior to introducing telemedicine to establish baseline. Post-introduction of telemedicine, YCH will start to survey members of the target population who utilized telemedicine to test the consequences of telemedicine on patient satisfaction.**		
DY 2 (10/1/2012-9/30/2013)	DY 3 (10/1/2013-9/30/2014)	DY 4 (10/1/2014-9/30/2015)	DY 5 (10/1/2015-9/30/2016)
Process Milestone 1: P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project plan Process Milestone 1 Estimated Incentive Payment: $28,287	Process Milestone 2: P-2 Establish baseline rates of patient satisfaction rates. Data Source: Patient satisfaction results in target population of new and established Medicaid/Medicare/commercial insurance patients in the two RHC's prior to introduction of telemedicine. Estimated Milestone 3 Incentive Payment: $31,388	Outcome Improvement Target 1: IT-6.1 Improvement Target: Improvement in patient satisfaction scores among target population of new and established Medicaid/Medicare/commercial insurance patients in the two RHC's through telemedicine. Amount of improvement TBD in DY3. Data Source: Patient satisfaction results in target population of new and established Medicaid/Medicare/commercial insurance patients in the two RHC's through telemedicine. Estimated Outcome Improvement Target 1 Incentive Payment:$47,931	Outcome Improvement Target 1: IT-6.1 Improvement Target: Improvement in patient satisfaction scores among target population of new and established Medicaid/Medicare/commercial insurance patients in the two RHC's through telemedicine. Amount of improvement TBD in DY3. Data Source: Patient satisfaction results in target population of new and established Medicaid/Medicare/commercial insurance patients in the two RHC's through telemedicine. Estimated Outcome Improvement Target 1 Incentive Payment:$110,197
DY 2 Estimated Outcome Amount: $28,287	DY 3 Estimated Outcome Amount: : $31,388	DY 4 Estimated Outcome Amount: $47,931	DY 5 Estimated Outcome Amount: $110,197
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:$217,804			

E. Category 4: Population Focused Improvements (Hospitals Only)

Category 4 Population-Focused Improvements (Hospitals only)

Performing Provider: Collingsworth General Hospital

Provider TPI: 126840107

Domain	Description
Potentially Preventable Admissions	**Unique Project ID: 126840107.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. Collingsworth General Hospital currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. Unique Project ID: 126840107.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. In DY2 we will assess the capability of our systems to generate appropriate data, develop an "Admissions by Chronic Diagnosis" report, a patient database, and the measures in this domain. . Data will be submitted via the template provided by HHSC, including data provided by HHSC (PPEs)**
Potentially Preventable Readmissions – 30 days	**Unique Project ID: 126840107.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. Collingsworth General Hospital currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. Unique Project ID: 126840107.2. 3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing readmissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. In DY2 we will assess the capability of our systems to generate appropriate data, develop an "Admissions by Chronic Diagnosis" report, a patient database, and the measures in this domain. Data will be submitted via the template provided by HHSC, including data provided by HHSC (PPEs)**

Potentially Preventable Complications	**Unique Project ID: 126840107.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being and our overall admissions to our hospital. Collingsworth General Hospital currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. Unique Project ID: 126840107.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. We feel that if the patient is satisfied with their care they will be more compliant with their treatment plan, seek treatment earlier, and experience fewer complications when hospitalized In DY2 we will assess the capability of our systems to generate appropriate data, develop a "Potentially Preventable Complications" report, a patient database, and the measures in this domain (reporting will not begin until DY4). Data will be submitted via the template provided by HHSC, including data provided by HHSC (PPEs).**
Patient-Centered Healthcare	**Unique Project ID: 126840107.2.1 When we provide a supportive environment and patients are satisfied with the care that they have received from our doctors, nurses and other health care team then the potential for compliance with the preventive or treatment plan is much more likely. This project will have no impact on medication management. Surveys will include questions relating to care received from physicians and nurses, the hospital environment and the discharge experience. Unique Project ID: 126840107.2. 3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. This project will have no impact on medication management.**
Emergency Department	**Unique Project ID: 126840107.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. Collingsworth General Hospital currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. This project has no impact on domain measure of ED admit decision time to ED departure time. Unique Project ID: 126840107.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. By improving our patient overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. We feel that if the patient is satisfied with their care they will seek treatment in our clinic before having to utilize our Emergency Room This project has no impact on domain measure of ED admit decision time to ED departure time.**
Children and Adult Core Measures (OPTIONAL)	**Exempt – Optional: We are opting not to participate in at this time because we feel that our time, effort, and resources will be more effective focusing on the health concerns mentioned**

	in our project plan.

Domain Valuation : Collingsworth General Hospital has adopted the regional valuation set forth by RHP 12. Based on this methodology, 5 percent of the total valuation in DY2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

Category 4: Population-Focused Measures *Collingsworth General Hospital/126840107*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	2,010	931		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		931	996	1,083
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		931	996	1,083
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			996	1,083
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/15-9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		931	996	1,083
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		931	996	1,083
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$2,010	$4,655	$4,980	$8,558

Category 4: Population-Focused Improvements (Hospitals only)

Performing Provider: Covenant Children's Hospital/127319504

- **Domain Descriptions:**

  Covenant Children's Hospital has identified the following DSRIP projects.

  I. IV. 127319504.2.1: Covenant Children's Hospital Asthma Navigation Program
     - 2.9 Establish/Expand a Patient Care Navigation Program,

  Targeted Outcome Improvements for select populations include the following Category 3 measures.

  I. OD-9 Right Care, Right Setting
     - IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits

Category 4 domains and measures will be impacted (see below) by this intervention targeting pediatric asthmatic patients who have a high-risk of admission, readmission, and ED utilization. Additionally, through the quality intervention regarding sepsis which is a Covenant Medical Center project will include the Covenant Children's Hospital, PPCs will also be impacted as the Covenant Health System continues to build its commitment to fight infection and complications.

The metrics in Category 4 will be captured at an aggregate level and at the physician level. The purpose of doing so will be to display the results on a virtual monthly physician performance scorecard. With regards to the Children's hospital: uncontrolled diabetes, pediatric asthma, and flu vaccinations will be tracked closely in subsequent years. After initial reporting of these metrics- efforts to broaden and expand our patient navigation program to diabetes may be needed. Patient education will be key if we are to see improved results year after year. HCAHPS will be collected and reported out on a monthly basis. The categories regarding physician communication, care from nursing staff, hospital environment and hospital discharge are being collected monthly by Avatar and are being reported to leadership staff and physicians. Physicians will receive their personal HCAHPS scores each quarter. Because many of the proposed DSRIP projects improve communication, quality and coordination of care; HCAHPS scores should improve. Care Coordination will specifically impact physician communication, care from nursing staff, and hospital discharge HCAHPS results. This will be due to team collaboration involving the patient, patients' family, physician, nursing staff and care coordination team. Care Coordination efforts are sure to improve medicine reconciliation efforts. Because a warm handoff occurs in the inpatient setting with our care coordinators, the patient, and their family; one the care coordinators initial tasks will involve the review of medicine for reconciliation upon discharge. This is currently conducted through a paper based approach. In fall 2013 Covenant Health

will become completely electronic and computer physician order entry will prompt the completion of med reconciliation forms and discharge orders through a series of electronic prompts. Emergency Department admits decision time are currently being monitored on a daily basis and reported out as a performance improvement metric on a monthly basis to individual physicians. In conjunction with care coordination efforts we plan to see improved right care right setting for asthma patients. The Care coordination team will be available as a resource to help asthmatic patients in the ambulatory care setting. This new level of patient engagement will facilitate a relationship where the Care coordination team will aid the patient in controlling their asthma to reduce emergency room visits. We hope to impact admit decision time to ED departure through education by providers regarding PCP and PCP appointments established in ED. Non-emergent patients will establish PCP and thus open access to ED for true emergencies. Based on performance with these established metrics Covenant Health Partners, a clinical integration program, will consider options to incorporate these metrics into their physician pay for performance program. This focus on reducing potentially preventable readmissions and admissions will not only help drive quality and efficiency but also produce savings.

At this point we have chosen to not participate in the optional domain due to the lack of information regarding the definition of which physicians should be involved in the reporting of these metrics. Many of the optional metrics involve physician specific and or claims based data. We currently do not have the capability to capture office practice claims data for private physicians.

Domain	Description
Potentially Preventable Admissions	Navigation services for children with asthma will increase management of the child's condition and potentially prevent acute episodes which can lead to inpatient stays.
Potentially Preventable Readmissions – 30 days	Navigation services for children with asthma will increase management of the child's condition and potentially prevent acute episodes which can lead to inpatient stays.
Potentially Preventable Complications	Though not directly related, patients with chronic conditions often are more susceptible to infection. Thereby the PPC rate could be impacted by the navigation project.
Patient-Centered Healthcare	Navigation services strategically focus on the patient and empowering the immediate care giver for a child with asthma. This focus should impact survey scores related to discussions with the provider team and knowing when and how to get appointments and follow up care.
Emergency Department	Navigation services will target patients who have a high-risk of admission, readmission, and ED utilization. Thereby through this intervention, we expect PPVs, specifically by this target population, to be reduced.
Children and Adult Core Measures (OPTIONAL)	N/A

- **Domain Valuation:**

  RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP

Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally.

Category 4: Population-Focused Measures Covenant Children's Hospital/127319504				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$146,303.00	$67,833.00		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$67,833.00	$72,566.00	$78,876.00
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$67,833.00	$72,566.00	$78,876.00
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$72,566.00	$78,876.00
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$67,833.00	$72,566.00	$78,876.00
Domain 5: Emergency Department				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$67,833.00	$72,566.00	$78,876.00

OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$ 0.00	$0.00	$0.00
Grand Total Payments Across Category 4	$146,303.00	$339,165.00	$362,830.00	$394,380.00

Category 4: Population-Focused Improvements (Hospitals only)

Performing Provider: Covenant Medical Center/139461107

- **Domain Descriptions:**

  Covenant Medical Center has identified the following DSRIP projects.

  I. 139461107.2.1: Sepsis Quality Initiative
     - 2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency

  II. 139461107.2.2: Covenant Adult Patient Navigation Program
     - 2.9 Establish/Expand a Patient Care Navigation Program

  III. 139461107.2.3: Covenant Transitional Outpatient Psychiatric Clinic
     - 2.17 Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.

  IV. 139461107.2.4: Covenant Outpatient Palliative Clinic
     - 2.10 Use of Palliative Care Programs, and

  Targeted Outcome Improvements for select populations include the following Category 3 measures.

  II. OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions
     - IT-4.8 Sepsis Mortality

  III. OD- 3 Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRS)
     - IT-3.12 Other: Diabetes Risk-Adjusted 30 Day Readmission Rate (Standalone measure)

  IV. OD-10.1 Quality of Life
     - IT-10.1 Quality of Life

  V. OD- 13 Palliative Care
     - IT-13.1 Pain Assessment
     - IT-13.3 Spiritual Care
     - IT-13.5 Treatment preferences

  Category 4 domains and measures will be impacted by these interventions targeting patients who have a high-risk of admission, readmission, and ED utilization in the different specialty areas. PPCs will also be impacted as Covenant Health System continues to build its commitment to fight infection and complication through the Sepsis Intervention. Covenant will

be able to track quality metrics in category 4 regarding the outcomes and improve processes identified for the following chronic conditions: Diabetes, CHF, COPD, CAD, Adult Asthma and Obesity through Category 2 Adult Navigation program. A reporting process will be implemented quarterly with the project teams for data generated by Category 4 metrics. The initial data from all of the metrics in Category 4 will help Covenant Health System establish a baseline which will make it possible to capture impact through DY5. We will provide reports to HHSC to ensure compliance with the reporting requirements.

Potentially preventable admissions and Potentially Preventable Readmissions contain viable metrics in Category 4 specifically related to Diabetes, CHF, and COPD. The Covenant Adult Patient Navigation Program will impact Domains 1 and 2 through increased patient assistance and guidance to primary and preventive care when appropriate in lieu of hospitalization. The Patient Navigators will be specifically trained in identifying and providing assistance and creating behavior change for patients who present with these specific diseases. Having the infrastructure that navigation provides will not only address our patient's needs but will also impact their outcomes by bridging gaps in care, improve access and increase utilization of PCP services. We will use these metrics to monitor the success and impact of an Adult Navigator program going forward. Covenant is also proposing the Covenant Transitional Outpatient Psychiatric Clinic that will directly impact behavioral health/substance abuse 30 day potentially preventable readmissions and avoidable admissions by providing a community resource not otherwise available. The Covenant Outpatient Palliative Clinic will also impact Domains 1 and 2 by providing access to outpatient care.

Potentially Preventable Complications apply to the chronic diseases and initiatives we are tracking in Category 2 Sepsis Initiative. Covenant's focus on reducing complications of care will result in cost savings and will increase quality as well as improved patient experiences. Many of the metrics in Category 4 will be adopted into Covenant's clinical integration program with certain metrics being adapted in a physician pay for performance program as well.

Domain 4 related to Patient Satisfaction and Medication Management is expected to be impacted as patients are more engaged and direct their treatment plans through the Covenant Outpatient Palliative Clinic. HCAHPS will be collected and reported out on a monthly basis. The categories regarding physician communication, care from nursing staff, hospital environment and hospital discharge are being collected monthly by Avatar and are being reported to leadership staff and physicians. Physicians will receive their personal HCAHPS scores each quarter. Because many of the proposed DSRIP projects improve communication, quality and coordination of care; HCAHPS scores should improve. Care Coordination will specifically impact physician communication, care from nursing staff, and hospital discharge HCAHPS results. This will be due to team collaboration involving the patient, patients' family, physician, nursing staff and care coordination team. Improved care regarding the sepsis program will create improved patient satisfaction due to an improved quality of life. Care Coordination efforts are sure to improve medicine reconciliation efforts. Because a warm handoff occurs in the inpatient setting with our care coordinators, the patient, and their family; one the care coordinators initial tasks will involve the

review of medicine for reconciliation upon discharge. This is currently conducted through a paper based approach. In fall 2013 Covenant Health will become completely electronic and computer physician order entry will prompt the completion of med reconciliation forms and discharge orders through a series of electronic prompts. We expect the Covenant Transitional Outpatient Psychiatric Clinic to also increase medication compliance and result in better outcomes for patients by adding an additional layer of oversight as patients' transition from one episode of care to another.

RD-5

Emergency Department admits decision time are currently being monitored on a daily basis and reported out as a performance improvement metric on a monthly basis to individual physicians. Emergency Department admits decision time will also be impacted by the Covenant Outpatient Palliative Clinic in a proposal submitted in Category 2. This proposal will address the vital decisions made by patients with chronic conditions and provide documentation when they come through the Emergency Department and need palliative and or end of life care. Pain management activities will also likely reduce the burden on the ED in transitioning patients from the ED setting to Palliative medicine. We hope to see reduced ED waiting times for patients who qualify for the Covenant Outpatient Palliative Clinic.

At this point we have chosen to not participate in the optional domain due to the lack of information regarding the definition of which physicians should be involved in the reporting of these metrics. Many of the optional metrics involve physician specific and or claims based data. We currently do not have the capability to capture office practice claims data for private physicians.

Domain	Description
Potentially Preventable Admissions	Covenant expects three projects, Covenant Adult Patient Navigation Program, the Covenant Transitional Outpatient Psychiatric Clinic, and the Covenant Outpatient Palliative Clinic, to improve our PPA rate. Through the Covenant Adult Patient Navigation Program, patients with chronic conditions including Diabetes, CHF, COPD, CAD, Adult Asthma and Obesity will be targeted for proven, evidence-based navigation services. Through the Psychiatric Clinic, we expect to create capacity and availability for services in the community and avoid potentially preventable crisis and episodic inpatient care. Through the Palliative Care Clinic, we expect patients to achieve better pain management, direct their treatment options, and receive spiritual care, which can all reduce potentially preventable admissions through better care management.
Potentially Preventable Readmissions – 30 days	Covenant expects three projects, the Covenant Adult Patient Navigation Program, the Covenant Transitional Outpatient Psychiatric Clinic, and the Covenant Outpatient Palliative Clinic, to improve our PPR rate. Through the Covenant Adult Patient Navigation Program, patients with chronic conditions including Diabetes, CHF, COPD, CAD, Adult Asthma and Obesity will be targeted for proven, evidence-based navigation services. Through the Psychiatric Clinic, we expect to create capacity and availability for services in the community and avoid potentially preventable crisis and episodic inpatient care. We also expect that transitional care, which is a service component of the Psychiatric Clinic, will improve readmission rates through medication management services and follow up care and appointments for discharging patients. Through the Palliative Care Clinic, we expect patients discharging with life threatening conditions to achieve better pain management, be able to direct their treatment options, and receive spiritual care, which can all reduce potentially preventable readmissions through better care management.
Potentially Preventable Complications	PPCs will also be impacted as Covenant Health System continues to build its commitment to fight infection and complications through the Sepsis Intervention. This project is housed within our Clinical Effectiveness Program and will be implemented System wide so that Levelland, Plainview, Covenant Children's and Covenant Medical Center all have improved rates.
Patient-Centered Healthcare	Patient Satisfaction and Medication Management is expected to be impacted as patients are more engaged and direct their treatment plans through the Covenant Adult Patient Navigation Program, the Covenant Transitional Outpatient Psychiatric Clinic and the Covenant Outpatient Palliative Clinic. Specifically, we expect the Covenant Transitional Outpatient Psychiatric Clinic to increase medication compliance and result in better outcomes for patients. We expect the Covenant Adult Patient Navigation Program to increase patient satisfaction in regard to care management and discussions with their care teams, and we expect the Covenant Outpatient Palliative Clinic to both increase patient and family satisfaction for patients at end-of-life and provide them with the full array of care including spiritual.
Emergency Department	The Covenant Adult Patient Navigation Program, the Covenant Transitional Outpatient Psychiatric Clinic and the Covenant Outpatient Palliative Clinic are all outpatient service expansions to enable patients to better care for themselves and to prevent emergencies. All three projects target chronic or ongoing medical conditions. The patients with chronic health conditions targeted through the Navigation Program will be educated on

	appropriate care settings for certain conditions. Often times, patients don't know what constitutes as a true emergency and what can be treated the next day at the doctor's office. Evidence based navigation services will provide education and information to patients to better manage their condition and reduce PPVs. Our vision for the Psychiatric Clinic is to be a place of refuge for patients in need of mental health services. Patients who have been admitted to the hospital through the ED may only remember the entrance door to the ED in order to access services. By expanding capacity through the Psychiatric Clinic and by educating discharging patients about the clinic, we intend to improve access to mental health services in the community. Through the Palliative Care Clinic, we are building capacity and services for patients who may need pain management therapy and patients who need to discuss treatment options. Patients with life threatening conditions have changing needs and often only have the ED as a place of consultation and pain therapy. The clinic will provide an outpatient and specialized care setting for these patients' changing treatment needs.
Children and Adult Core Measures (OPTIONAL)	N/A

- **Domain Valuation:**

  RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally.

Category 4: Population-Focused Measures Covenant Medical Center/139461107				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 727,846.00	$ 337,467.00		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 337,467.00	$ 361,011.00	$ 392,404.00
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 337,467.00	$361,011.00	$392,404.00
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$361,011.00	$392,404.00
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$ 337,467.00	$361,011.00	$392,404.00
Domain 5: Emergency Department				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$ 337,467.00	$361,011.00	$392,404.00

OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$ 0.00	$0.00	$0.00
Grand Total Payments Across Category 4	$ 727,846.00	$ 1,687,335.00	$ 1,805,055.00	$ 1,962,020.00

Category 4 Population-Focused Improvements

Performing Provider: Golden Plains Community Hospital/197063401

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – GPCH will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. GPCH expects that its provision of expanded primary care services through existing local clinics will reduce the number of PPAs over the life of the Waiver. More specifically, GPCH hopes that patients with chronic diseases will be better able to engage in self-management goals and activities of daily living with the support, education, and services that primary care providers participating with GPCH in this project can offer to a currently underserved patient population.

- **Valuation Rationale/Justification** – The value GPCH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in Hutchinson County will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. GPCH values this reporting domain at $399,980 over Demonstration Years 3-5, requiring local funding of $165,231.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – GPCH will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. GPCH expects that its provision of expanded primary care services through existing local clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Additionally,

GPCH plans to implement chronic disease management registry functionality that will enable clinical staff to provide more coordinated support to Hutchinson County patients diagnosed with COPD, a common chronic disease in the community. This project will result in COPD patients receiving better follow-up after discharge, decreasing the likelihood of costly and preventable readmissions. GPCH also plans to strengthen the outpatient services available to post-discharge patients through the implementation of a medical home model at its Borger facility, further reducing the need of chronically ill patients to rely upon costlier, less appropriate inpatient services.

- **Valuation Rationale/Justification** - The value GPCH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in Hutchinson County will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Many hospitalizations at GPHC can be linked to manageable chronic diseases that GPHC intends to address with its project to expand access to primary care. GPCH values this reporting domain at $399,980 over Demonstration Years 3-5, requiring local funding of $165,231.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – GPCH will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and GPCH is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. GPCH expects that its Category 1 project to expand access to primary care will reduce the strain on GPCH's hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, GPCH can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver.

- **Valuation Rationale/Justification** - The value GPCH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will

require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. GPCH values this reporting domain at $268,457 over Demonstration Years 3-5, requiring local funding of $110,899.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – GPCH will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. GPCH is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. GPCH expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with GPCH's Category 1 project to expand primary care access, and its Category 1 project to improve chronic disease management, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value GPCH placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from GPCH and how well GPCH performs its function of promoting medication management. GPCH is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Hutchinson County is costly to patients' health and to the delivery system, and GPCH believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. GPCH values this reporting domain at $399,980 over Demonstration Years 3-5, requiring local funding of $165,231.

Domain 5: Emergency Department (1 measure)

- **Description** – GPCH will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with GPCH's Category 2 project to reduce inefficiencies the ED, because an effect of this project's successful implementation will be to reduce overall ED treatment, admit, and discharge times. One cause of extended ED departure times results from an overcrowded ED, so GPCH also intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which GPCH expects will reduce the number of inappropriate ED visits.

- **Valuation Rationale/Justification** - The value GPCH placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. GPCH values this reporting domain at $399,980 over Demonstration Years 3-5, requiring local funding of $165,231.

Category 4: Population-Focused Measures Golden Plains Community Hospital – TPI: 197063401				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$169,219	$91,524.60		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$91,524.60	$113,063.60	$135,394
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$91,524.60	$113,063.60	$135,394
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$113,063.60	$135,394
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$91,524.60	$113,063.60	$135,394
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$91,524.60	$113,063.60	$135,394
OPTIONAL Domain 6: Children and Adult Core Measures				

Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$169,219	$457,623	$ 565,318	$676,970

Category 4: Population-Focused Improvements (Hospitals only)

Performing Provider: Grace Medical Center/281514401

Domain	Description
Potentially Preventable Admissions	Potentially Preventable Admissions (PPA's) are typically the result of poor healthcare access, especially evidenced in the underserved populations of uninsured and low-income Medicaid recipients. Grace has chosen Category One project, 1.1.2, Expand Existing Primary Care Capacity. By adding 2 providers, extended hours and new physical space located in the HPSA area, patients will have better access to primary care which will result in better chronic disease management and reduced admissions related to acute manifestations of these conditions.
Potentially Preventable Readmissions – 30 days	Expanding Existing Primary Care capacity will provide underserved patients that are admitted to the hospital who do not have a primary care physician access to care and medical management post discharge, in turn, providing for the potential to reduce readmissions.
Potentially Preventable Complications	By expanding primary care access, disease management techniques can be applied to the underserved population. Such tactics have the potential to reduce complications due to disease state.
Patient-Centered Healthcare	For the purpose of this project, Patient Centered Healthcare is comprised of two components: Patient Satisfaction and Medication Management in the inpatient setting. Grace, since its inception, has focused intently on patient satisfaction and continues to maintain this priority as a house-wide processes improvement priority. Conduct Medication Management: Grace will conduct medication management counseling and reconciliation to patients upon discharge from acute care. The intent of the Grace medication reconciliation management program is to improve medication efficacy and safety in targeted high risk patient population during the critical transitional phase from hospital to home. Patients who receive counseling and reconciliation are more likely to have and adhere to an appropriate medication regimen, thereby increasing patient's satisfaction and effectiveness of the care provided.
Emergency Department	Grace has chosen Category 1 project 1.1.2 - Expanding Existing Primary Care Capacity. By providing access to a new clinic with 2 new providers and extended hours, new access to primary care will be available to the underserved, resulting in reduced reliance on the ED to provide primary care activities. This project will not impact the decision time to transfer a patient to a different hospital.
Children and Adult Core Measures (OPTIONAL)	Unable to participate. Grace Medical Center does not provide obstetric inpatient care.

- **Domain Valuation:**

  RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally.

Category 4: Population-Focused Measures Grace Medical Center/281514401				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$33,791	$15,667		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$15,667	$16,760	$18,217
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$15,667	$16,760	$18,217
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$16,760	$18,217
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$15,667	$16,760	$18,217
Domain 5: Emergency Department				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive		$15,668	$16,761	$18,218

Amount				
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$ 0.00	$0.00	$0.00
Grand Total Payments Across Category 4	$33,791	$78,336	$83,801	$91,088

Category 4: Population-Focused Improvements (Hospitals only)

Performing Provider: Pampa Regional Medical Center/178848102

- **Domain Descriptions:**

  Pampa Regional Medical Center has identified the following DSRIP projects.

  I. 1.1.2 Expand Primary Care Capacity, Expanding existing primary care capacity

  Targeted Outcome Improvements for select populations include the following Category 3 measures.

  VI. OD-1-Primary Care and Chronic Disease Management
  - IT-1.7 Controlling High Blood Pressure

Category 4 domains and measures will be impacted (see below) by this intervention targeting patients with high blood pressure who have a high-risk of admission, readmission, and ED utilization. Additionally, through expanding primary care capacity and expanding existing primary care capacity Pampa Regional Medical Center will give patients access to primary and preventive care which will which will allow to manage chronic diseases such as high blood pressure. Additionally it will help reduce readmission rates for patients who have limited access to primary providers and it will decrease miss utilization of the emergency departments.

The metrics in Category 4 will be captured at an aggregate level, a hospital level and a clinic level. The purpose of doing so will be to display the results on a monthly spreadsheet. With regards to new primary care providers and to Pampa Regional Medical Center: patients with high blood pressure will be tracked closely in subsequent years. . Patient education will be key if we are to see improved results year after year. This provider will monitor Congestive Heart Failure admissions to identify potentially preventable complications for our in patients. This will be accomplished by forming a task force team for monitoring/teaching/and discharge planning as well as collaborating with other healthcare providers. This focus on reducing potentially preventable readmissions and admissions will not only help drive quality and efficiency but also produce savings.

At this point we have chosen to not participate in the optional domain due to the lack of information regarding the definition of which physicians should be involved in the reporting of these metrics. Many of the optional metrics involve physician specific and or claims based data.

Domain	Description
Potentially Preventable Admissions	Providing primary care physicians for patients with uncontrolled high blood pressure will increase management of these patients and potentially prevent and potentially prevent acute episodes which can lead to inpatient stays.
Potentially Preventable Readmissions – 30 days	Providing primary care physicians for patient s with hypertension will increase management of the condition, ensure medication compliance, and continued education and potentially prevent acute episodes which can lead to inpatient stays.
Potentially Preventable Complications	Many complications are caused by uncontrolled high blood pressure such has congested heart failure, strokes, aneurysms, weakened and narrowed blood vessels in the kidneys, and metabolic syndrome just to name a few. The rate of potentially preventable complications would be impacted by the controlling of high blood pressure. Congested Heart Failure in patients would be monitored in collaboration with high blood pressure
Patient-Centered Healthcare	PRMC will provide patients and their providers with Medication Reconciliation Discharge sheets identifying patients current medication, new medications started in hospital and medications that have been discontinued during their hospital stay. The list will include the drug, dose and frequency to be taken. Post discharge phones calls will be made to follow up any questions patient may have after being discharged from facility. PRMC will monitor patient satisfaction through the use of an outside vender to acquire HCAHP scores. PRMC will strategically focus on the patient and empowering the patient to manage their high blood pressure with education of diet, medications and follow up care. The access to primary care providers, no matter of their payer source, will aide in overall improvement of patients managing their disease process.
Emergency Department	Through interventions provided by primary care provides, we expect to decrease the burned that is placed on the Emergency Department of seeing patients with acute or chronic conditions instead of emergent medical needs. PRMC will target those patients with no primary care providers.
Children and Adult Core Measures (OPTIONAL)	N/A

- **Domain Valuation:**

  RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally.

Category 4: Population-Focused Measures Pampa Regional Medical Center 178848102				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$43,294	$20,073		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$20,073	$21,474	$23,341
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$20,073	$21,474	$23,341
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$21,474	$23,341
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$20,073	$21,474	$23,341
Domain 5: Emergency Department				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$20,073	$21,474	$23,341

OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$ 0.00	$0.00	$0.00
Grand Total Payments Across Category 4	$43,294	$100,366	$107,369	$116,705

Category 4 Population-Focused Improvements (Hospitals only)

Performing Provider: Parmer Medical Center/137343308

Domain	Description
Potentially Preventable Admissions	**Unique Project ID: 137343308.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. Parmer Medical Center currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. Unique Project ID: 137343308.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. In DY2 we will assess the capability of our systems to generate appropriate data, develop an "Admissions by Chronic Diagnosis" report, a patient database, and the measures in this domain Data will be submitted via the template provided by HHSC, including data provided by HHSC (PPEs)**
Potentially Preventable Readmissions – 30 days	**Unique Project ID: 137343308.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. Parmer Medical Center currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. Unique Project ID: 137343308.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing readmissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. In DY2 we will assess the capability of our systems to generate appropriate data, develop an "Admissions by Chronic Diagnosis" report, a patient database, and the measures in this domain Data will be submitted via the template provided by HHSC, including data provided by HHSC (PPEs)**
Potentially Preventable Complications	**Unique Project ID: 137343308.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and wellbeing and our overall admissions to our hospital. Parmer Medical Center currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. Unique Project ID: 137343308.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. We feel that if the patient is**

	satisfied with their care they will be more compliant with their treatment plan, seek treatment earlier, and experience fewer complications when hospitalized. . In DY2 we will assess the capability of our systems to generate appropriate data, develop a "Potentially Preventable Complications" report, a patient database, and the measures in this domain (reporting will not begin until DY4 Data will be submitted via the template provided by HHSC, including data provided by HHSC (PPEs)
Patient-Centered Healthcare	**Unique Project ID: 137343308.2.1 When we provide a supportive environment and patients are satisfied with the care that they have received from our doctors, nurses and other health care team then the potential for compliance with the preventive or treatment plan is much more likely. This project will have no impact on medication management Unique Project ID: 137343308.23 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. When you have better continuum of care you are potentially preventing admissions due to the overall satisfaction of being on top of patient care which results in better patient satisfaction with that patient. This project will have no impact on the medication management indicator**
Emergency Department	**Unique Project ID: 137343308.2.1 By implementing a system to manage our chronic care patients we will be improving our patients overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. Parmer Medical Center currently has valuations for this domain in Category 4, excluding the optional reporting for this domain. This project has no impact on the domain measure of ED admit decision time to ED departure time. Unique Project ID: 137343308.2.3 By implementing and expanding patient satisfaction tools the hospital plans to elicit comments in order to provide better continuum of care. By improving our patient overall health and well being as well as effectively decreasing our usage of our emergency room department and our overall admissions to our hospital. We feel that if the patient is satisfied with their care they will seek treatment in our clinic before having to utilize our Emergency Room. This project has no impact on the domain measure of ED admit decision time to ED departure time.**
Children and Adult Core Measures (OPTIONAL)	**Exempt – Optional: We are opting not to participate in at this time because we feel that our time, effort, and resources will be more effective focusing on the health concerns mentioned in our project plan.**

Domain Valuation : Parmer Medical Center has adopted the regional valuation set forth by RHP 12. Based on this methodology, 5 percent of the total valuation in DY2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

Category 4: Population-Focused Measures *Parmer Medical Center/137343308*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$8,831	$4,023		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$4,023	$4,220	$4,518
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$4,023	$4,220	$4,518
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$ 996	$4,518
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/15-9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$5023	$4220	$4518
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$4023	$4220	$4518
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$8,831	$17,092	$17,876	$22,590

Category 4: Population-Focused Improvements (Hospitals only)
Performing Provider: Sunrise Canyon Hospital (SRCH)/136492909

Domain Descriptions:

Sunrise Canyon Hospital has identified the following DSRIP projects.

136492909.2.13: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.

- 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

Targeted Outcome Improvements for select populations include the following Category 3 measures.

OD-9 Right Care, Right Setting

- IT-9.2 ED Appropriate Utilization/Reduce ED visits for target populations (Behavioral Health/Substance Abuse)

Project Description: One in four adults, approximately 57.7 million Americans, experiences a mental health issue every year.[45] For the average family, nothing is more confusing or devastating than trying to help a loved one struggling with a mental illness. In Lubbock, as throughout the rest of the country, the focus in healthcare is on decreasing cost and improving outcomes. This project proposes a methodology to accomplish both of these goals, reduction of cost through diversion of people whose primary need is access to health care from emergency departments, inpatient settings and jail, into a more effective and efficient delivery system of care.

During Pass 2, Sunrise Canyon Hospital (SRCH) will implement a project opening a new integrated primary and behavioral health clinic. Many people discharged from SRCH do not meet eligibility for ongoing outpatient services; neither do many people released from the criminal justice system. This project will allow those people as well as others to have access to urgently needed psychiatric care and medications, as well as access to routine physical medical care. [Note: SRCH is owned by StarCare Specialty Health System, but is eligible to submit an independent project during Pass 2. The new integrated clinic described herein is totally separate from StarCare Specialty Health System's integrated health care clinic. Each clinic will serve a different population of people.] SRCH's new integrated primary and behavioral health care clinic will serve adolescents and adults discharged from the Psychiatric Emergency Services Center (PESC – StarCare Specialty Health System's Pass 1 Project) as well as people in the general public, including people who are homeless, people recently released from jail, veterans, etc. SRCH estimates it will provide at least 600 office visits annually during DY4 and DY5 and expects to serve at least 225 people annually in DY4 and DY5, 95% of whom are expected to be Medicaid eligible or indigent. SRCH's new integrated primary and behavioral health clinic will be housed inside the PESC facility so as to promote continuity of care and ease of access.

[45] *NIMH: The numbers count—Mental Disorders in America,* National Institute of Health, available at www.nimh.nih.gov/publicat/numbers.cfm

SRCH will provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical issues. These populations often have multiple concomitant issues such as substance abuse, traumatic injuries, homelessness, cognitive challenges and lack of daily living skills and lack of natural supports. The State's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and functional limitations, but can serve only a fraction of the medically indigent population. It does not serve other high risk behavioral health populations and does not provide the range of services needed to deal with complex psychiatric and physical needs. These complex populations become frequent users of local public health systems.

Goal of Project: The primary goal of this project is to ensure people receive coordinated, timely and site-appropriate behavioral and physical health services. Specifically, SRCH will assist with averting outcomes such as potentially avoidable inpatient admission and readmissions in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community.

Domain	Description
Potentially Preventable Admissions	Potentially Preventable Admissions (PPA) and Emergency Department (ED) visit rates are population-level quality measures. They are the resulting measures of the qualities of the ambulatory care infrastructure and overall system to meet the patient needs. They are a measure of outcome rather than process. Sunrise Canyon has focused on category 1 & 2 projects to address PPAs. These include: Expansion of Primary and Behavioral Health Capacity – Sunrise Canyon plans to expand its access to behavioral and physical medicine through an additional clinic for the public, offering extended hours to accommodate the needs of general population. This access will benefit the underserved, resulting in better disease management and reduce admissions related to acute manifestations of these conditions. Expansion of Chronic Care Management – Sunrise Canyon will create a network of resources through the use of a database registry with health care professionals to engage in the management of those with a history of unstable chronic and persistent mental illnesses. Outreach and coaching will be the primary focus on those who are deemed high risk will be closely managed to encourage the individuals to be more involved in their own care and outcomes which will result in less hospital admissions over time.
Potentially Preventable Readmissions – 30 days	Potentially Preventable Readmissions<30 days are the result from incomplete treatment or poor care of the underlying problem, or may reflect poor coordination of services at the time of discharge and afterwards, such as incomplete discharge planning and/ or inadequate access to care. Sunrise Canyon will address the issue with the following: Urgent Medical Advice – The use of dedicated trained professionals to be available to address urgent primary and behavioral health advice to the public. This will allow the free flow of information to access as well as guidance to seek the most appropriate healthcare setting. This will result in lower hospital admissions as well as visits to the ED. Medication Management – Sunrise Canyon will conduct medication management upon discharge from Sunrise Canyon Hospital or discharge referrals from UMC. The intent is to improve the goals and safety for the

	targeted high-risk populations during the transitions from hospital settings to homes. More involvement from a medication management viewpoint allows the adherence to medication regime and reduces the likelihood of an immediate readmission to the hospital.
Potentially Preventable Complications	Potentially Preventable Complications are harmful events (accidental laceration during a procedure) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease. Sunrise Canyon will implement the following to address the PPCs: Performance Process Improvements – Internal supports in training and organizational effectiveness in performance improvement measures will lay the foundation for our baseline measures in reducing PCCs. Sunrise Canyon anticipates this will assist in reducing PCCs resulting from antiquated or inadequate practices. Chronic Care Management – As earlier discussed, Sunrise Canyon will be involved in practices involving data across EDs, clinical settings beyond Sunrise Canyon to provide a comprehensive view of care provided and to be provided. This registry will assist identifying the high-risk population and provide the data needed to monitor their outcomes.
Patient-Centered Healthcare	Patient-Centered Healthcare supports active involvement of patients and their families in the design of new care models and in decision-making about individual options for treatment. Chronic Care Management will be at the forefront in providing a holistic approach to medication management and the transition from hospital setting to home keeping the patient the focus on self-reliance to medication education and the impacts of the deviations from the plan of care. Patients who are educated on the impacts of medication regimes and relate those to positive outcomes impact the likelihood of a return visit to an ED and/or hospital admission.
Emergency Department	Overcrowded EDs for individuals with non-urgent services poses an impact on outcomes for both the entity providing the services and the recipient of those services. With the Expansion of the Primary and Behavioral Health Capacity, Sunrise Canyon's opportunity to provide an additional access point, the impact of the flow to EDs will be reduced. Through the functions of the Urgent Medical Advice plan, Sunrise Canyon will address urgent primary and behavioral health advice to the public. This will allow the free flow of information to access as well as guidance to seek the most appropriate healthcare setting.
Children and Adult Core Measures (OPTIONAL)	Sunrise Canyon Hospital will not be participating in this optional domain.

Domain Valuation:

RHP 12 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally. At this point we have chosen to not participate in the optional domain due to the lack of information regarding the definition of which physicians should be involved in the reporting of these metrics.

Category 4: Population-Focused Measures Sunrise Canyon Hospital/136492909				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, and 3.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 103,043	$ 45,862		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$ 45,862	$ 46,699	$ 48,810
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$ 45,862	$ 46,699	$ 48,810
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$ 46,699	$ 48,810
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$ 45,862	$ 46,699	$ 48,810
Domain 5: Emergency Department				
Measurement period for report		7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$ 45,862	$ 46,699	$ 48,810

Category 4 Population-Focused Improvements (Hospitals only)

Performing Provider: UNIVERSITY MEDICAL CENTER –LUBBOCK/137999206

Domain Description:

Domain	Description
Potentially Preventable Admissions	Potentially Preventable Admissions (PPA's) are typically the result of poor healthcare access, especially evidenced in the underserved populations of uninsured and low-income Medicaid recipients. UMC has chosen several Category 1 & 2 projects that will effectively reduce PPA's. These include: Expansion of Primary Care capacity, Enhancement of Urgent Medical Advice, and Expansion of Chronic Care Management models. -Expansion of Primary Care Capacity: UMC plans to expand capacity by opening 2 additional primary care clinics, expanding physical capacity in existing clinics, and extending hours to accommodate access. These tactics will increase access to all patients, including those typically underserved, resulting in better chronic disease management and reduced admissions related to acute manifestation of these conditions. -Enhancement of Urgent Medical Advice: UMC will implement a call center to provide urgent medical advice to patients. The call center will utilize state-of-the-art software to help clinicians place the patient in the most appropriate care setting. We anticipate that this tactic will have a significant impact on PPA's by reassuring patients about the urgency of their condition, and deferring care to a more appropriate time/location. -Expansion of Chronic Care Management: UMC will combine a chronic care registry with a team of healthcare professionals to actively manage patients with unstable chronic conditions. Through a combination of outreach and coaching, beyond the walls of traditional settings, these high-risk patients will be managed actively and aggressively to engage in their own care and outcomes and avoid acute complications requiring hospital admission.
Potentially Preventable Readmissions – 30 days	Potentially Preventable Readmissions (PPR's) are typically the result of poor follow-up and coordination between hospitals and downstream and/or primary healthcare providers. UMC has chosen several Category 1 & 2 projects that will effectively reduce PPR's. These include: Implementation of a Disease Registry, Implementation of an Urgent Medical Advice program, and Conduct Medication Management at discharge. -Implementation of Disease Registry: UMC will purchase a Disease Registry software system to allow for population management techniques to be applied against high-risk PPR target groups. These analytics, along with evidenced-based care reminders, will ensure that high-risk patients are being closely followed by a clinical team, and that the appropriate screenings and preventive measures are conducted during provider-patient encounters. This registry will use EMR data from across ambulatory, emergency, and acute care venues to provide a comprehensive picture of patient care. This software will be used to identify gaps in care between care settings, and allow UMC to implement processes to ensure care coordination is maximized. -Urgent Medical Advice Program: UMC will implement a call center to provide urgent medical advice to patients. The call center will utilize state-of-the-art software to help clinicians place the patient in the most appropriate care

	setting. We anticipate that this tactic will have a significant impact on PPA's by reassuring patients about the urgency of their condition, and deferring care to a more appropriate time/location. -Conduct Medication Management: UMC will conduct medication management counseling and reconciliation to patients upon discharge from acute care. The intent of the UMC medication management program is to improve medication efficacy and safety in targeted high risk patient populations during the critical transition phase from hospital to home. Patients who receive counseling and reconciliation are more likely to have and adhere to an appropriate medication regimen, thereby reducing the probability of a medication-related readmission.
Potentially Preventable Complications	Potentially Preventable Complications (PPC's) are typically defined as harmful events or negative outcomes that may result from the process of care and treatment rather than from a natural progression or result of the underlying disease state. UMC has chosen two Category 1 & 2 projects that will effectively reduce PPC's. These include: Implementation of a Disease Registry, and Enhancing Performance Improvement processes. -Implementation of Disease Registry: As mentioned above, UMC will purchase a Disease Registry software system to allow for population management techniques to be applied against high-risk PPC target groups. This registry will use EMR data from across ambulatory, emergency, and acute care venues to provide a comprehensive picture of patient care. The Registry will help identify high-risk target areas for PPC's and provide the data and analytics necessary to drive and measure improvements related to reducing PPC's. -Enhancing Performance Improvement processes: UMC intends to invest significantly to increase the effectiveness of our organizational PI process. By providing additional training and methodologies to leverage best practice and evidenced based guidelines more quickly and effectively, UMC hopes to significantly reduce PPC's that result from inadequate or outdates techniques and/or processes.
Patient-Centered Healthcare	For the purpose of this exercise, Patient Centered Healthcare is comprised of two components: Patient Satisfaction and Medication Management in the Inpatient setting. UMC has spent several years focused intently on our patient satisfaction, so our approach to this metric is to enhance our Medication Management processes. -Conduct Medication Management: UMC will conduct medication management counseling and reconciliation to patients upon discharge from acute care. The intent of the UMC medication management program is to improve medication efficacy and safety in targeted high risk patient populations during the critical transition phase from hospital to home. Patients who receive counseling and reconciliation are more likely to have and adhere to an appropriate medication regimen, thereby increasing patient satisfaction and effectiveness of the care provided.
Emergency Department	This metric relates to the ability of the ED provider to make a timely admit decision for critical patients and execute the transition to acute care in an expedient manner. UMC believes that the key to complying with this metric is to reduce overcrowding of the ED by patients with no urgent conditions. UMC has chosen two Category 1 & 2 projects that will help address this issue, thereby allowing ED caregivers to focus more directly on critically ill patients. -Expansion of Primary Care Capacity: UMC plans to expand capacity by opening 2 additional primary care clinics, expanding physical capacity in existing clinics, and extending hours to accommodate access. These tactics will increase access to all patients, including those typically underserved, resulting in reduced reliance on the ED to provide primary care activities. -Urgent Medical Advice Program: UMC will implement a call center to provide urgent medical advice to patients. The call center will utilize state-of-the-art software to help clinicians place the patient in the most appropriate care

	setting. We anticipate that this will help reduce unnecessary ED encounters by reassuring patients about the urgency of their condition, and deferring care to a more appropriate time/location.
Children and Adult Core Measures (OPTIONAL)	**We are opting not to participate in this optional domain.**

Domain Valuation: We have adopted the regional valuation set forth by RHP 12. Based on this methodology, 5 percent of the total valuation in DY2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains.

Category 4: Population-Focused Measures *University Medical Center/137999206*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 979,377	$415,516.60		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$ 415,516.60	$ 480,033.80	$ 519,314.60
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$ 415,516.60	$ 480,033.80	$ 519,314.60
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$ 480,033.80	$ 519,314.60
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1/1/2013 – 12/31/2013	1/1/2014 – 12/31/2015	1/1/2015-12/31/2016
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		1/1/2013 – 12/31/2013	1/1/2014-12/31/2015	1/1/2015-12/31/2016
Planned Reporting Period: 1 or 2		1	1	1

Domain 4 - Estimated Maximum Incentive Amount		$ 415,516.60	$ 480,033.80	$ 519,314.60
Domain 5: Emergency Department				
Measurement period for report		1/1/2013-12/31/2013	1/1/2014-12/31/2015	1/1/2015-12/31/2016
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$ 415,516.60	$ 480,033.80	$ 519,314.60
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$ 979,377	$ 2,257,889	$ 2,400,169	$ 2,596,573

Section VI. RHP Participation Certifications

See Attachment

Section VII. Addendums

SEE ATTACHED for the following documents:

- *Private hospital certifications – refer to Companion Document for additional details.*
- *List of DSRIP projects that were considered but not selected for inclusion in the RHP Plan*
- *Signed agreements of small hospitals participating in a collaboration in Pass 1 as allowed in the PFM Protocol, paragraph 25.c.iii.*
- *Signed agreements of Performing Providers that combined their Pass 2 allocations as allowed in the PFM Protocol, paragraph 25.d.iii.*
- *Optional: additional community assessment information*
- *Optional: supporting evidence of stakeholder participation (e.g. meeting lists, minutes, letters of support)*
- *Optional: additional valuation information*