Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

February 8, 2013

Region 15 / University Medical Center of El Paso

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REGION 15
REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN SUBMISSION

February 8, 2013

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PART ONE: INSTRUCTIONS

Each RHP in collaboration with the Intergovernmental Transfer (IGT) Entities and Performing Providers in the region must complete and submit a complete RHP Plan to HHSC by December 31, 2012. All sections are required unless indicated as optional.

RHPs shall refer to Attachment I (RHP Planning Protocol), Attachment J (RHP Program Funding and Mechanics Protocol), the RHP Plan Checklist, and Companion Document as guides to complete the sections that follow. This plan must comport with the two protocols and fulfill the requirements of the checklist.

The RHP Plan, Financial Workbooks, and RHP Plan Checklist must be submitted as electronic files in Microsoft Word and Excel on one CD compatible with Microsoft Office 2003. The Section VI RHP Plan Certifications and addendums may be submitted as PDF files. PDF files should be prepared in a format that allows for OCR text recognition. Include one hardbound copy of the RHP Plan (do not include hardbound copies of the financial workbook).

Each RHP must submit the complete RHP Plan (including the Financial Workbooks and RHP Plan Checklist) to HHSC Healthcare Transformation Waiver Operations (HTW) no later than **10:00 a.m. Central Time on December 31, 2012**. All submissions will be date and time stamped when received by HTW. It is the RHP's responsibility to appropriately mark and deliver the RHP Plan to HHSC by the specified date and time.

Please mail RHP Plan packets to:

Laela Estus, MC-H425
Texas Health and Human Services Commission
Healthcare Transformation Waiver Operations
11209 Metric Blvd.
Austin, Texas 78758

You must adhere to the page limitations specified in each section using a minimum 12 point font, tables a minimum 10 point font – otherwise the RHP Plan will be immediately returned.

HHSC will contact the RHP Lead Contact listed on the cover page with any questions or concerns. IGT Entities and Performing Providers will also be contacted in reference to their specific Delivery System Reform Incentive Payment (DSRIP) projects.

PART TWO: 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 *(specify type of Anchor, e.g. public hospital, governmental entity)*						
Public Hospital	138951211	17460007564	Public Hospital	University Medical Center of El Paso	James N. Valenti, President and Chief Executive Officer	jvalenti@umcelpaso.org 4815 Alameda Avenue El Paso, Texas 79905 (915) 521-7602
IGT Entities *(specify type of government entity, e.g. county, hospital district)*						
Academic Health Science Center	084597603	37397397391007012	Academic Health Science Center, State Owned	Texas Tech University Health Science Center	Michael J. Romano, MD, MBA, Associate Dean for Clinical Affairs, TTUHSC	michael.romano@ttuhsc.edu 4800 Alberta Avenue, Suite 101 El Paso, Texas 79905 (915) 545-5750 Fax (915) 545-5755
Local Mental Health Authority	127376505	17415961592	LMHA, Government Agency	Emergence Health Network	Kristen D. Daugherty, Chief Executive Officer	kdaugherty@EPMHMR.ORG 1600 Montana Avenue El Paso, Texas 79902 (915) 887-3410

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)
Local Health Department, Non-State Public Government	065086301	17460007499	Local Health Department, Non-State Public Government	City of El Paso Department of Public Health	Bruce Parsons, Interim Health Director	parsonsba@elpasotexas.gov 5115 El Paso Drive El Paso, Texas 79905 (915) 771-5702
Performing Providers *(specify type of provider, e.g. public or private hospital, children's hospital, CMHC, that will receive DSRIP payments under the RHP plan, some of which may also receive UC)*						
Private Hospital	094109802	17424999526	Private Hospital	Las Palmas Del Sol Healthcare	Cindy Sexton	cindy.sexton@hcahealthcare.com 18th floor 98 San Jacinto Blvd. Austin, Texas 78701
Private Hospital	130601104	19545377202501	Private Hospital	Providence Memorial Hospital	J. Eric Evans, Market Chief Executive Officer	eric.evans@tenethealth.com 2001 N. Oregon Street El Paso, Texas 79902-3320 (915) 577-6625 Fax (915) 577-6109
Private Hospital	196829901	19545377202008	Private Hospital	Sierra Providence East Medical Center	Sally Hurt, Chief Executive Officer	Sally.hurt@tenethealth.com 3280 Joe Battle Blvd. El Paso, Texas 79938 (915) 832-2000

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)
New Children's Hospital	2981854201	12630754294000	New Children's Hospital	El Paso Children's Hospital	Lawrence Duncan, Chief Executive Officer	LDuncan@elpasochildrens.org 4845 Alameda Avenue El Paso, Texas 79905 (915) 242-8600
UC-only Hospitals *(list hospitals that will only be participating in UC)*						
Private Hospital	133245406	19545377202003	Private Hospital	Sierra Medical Center	J. Eric Evans, Market Chief Executive Officer	eric.evans@tenethealth.com 1625 Medical Center Drive El Paso, Texas 79902 (915) 747-2634 Fax (915) 747-2550
State Psychiatric Hospital	112751605	35375375371000	State Psychiatric Hospital	Texas Dept. of State Health Services - El Paso Psychiatric Center	Olga Rodriguez, Director	olga.rodriguez@dshs.state.tx.us Center for Program Coordination and Health Policy Texas Department of State Health Services 1100 West 49th Street Austin, Texas 78756-3199 (512) 776-7181
Other Stakeholders *(specify type)*						
Non-Profit			Non-Profit	Paso del Norte Health Foundation	Jon Law, Executive Director	jlaw@pdnhf.org 221 N. Kansas, Suite #1900 El Paso, Texas 79901 (915) 544-7636

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)
FQHC			FQHC	Centro San Vicente Clinic	Donald M. Tufts, CEO	dtufts@csv.tachc.org 8061 Alameda Avenue El Paso, Texas 79915 (915) 225-0670
Non-Profit			Non-Profit	International AIDS Empowerment	Skip Rosenthal, Executive Director	skiprosenthal@internationalaids.org 800 Montana Avenue El Paso, Texas 79902 (915) 590-2118
FQHC			FQHC	Project Vida Health Center	Bill Schlesinger, CEO	bschlesinger.pv@tachc.org 3607 Rivera Avenue El Paso, Texas 79905 (915) 533-7057
Non-Profit			Non-Profit	Hospice of El Paso, Inc.	Miguel Marquez, CFO	miguelm@hospiceelpaso.org 1440 Miracle Way El Paso, Texas 79925 (915) 532-5699
Private Hospital			Private Hospital	El Paso Specialty Hospital	James Wilcox, CEO	jwilcox@nshinc.com 1755 Curie Drive, Suite #A El Paso, Texas 79902 (915) 534-1249
Non-Profit			Non-Profit	El Paso Coalition for the Homeless	Carol H. Bohle, Executive Director	cbohle.epch@elp.twcbc.com 6044 Gateway East, Suite 211 El Paso, Texas 79905 (915) 843-2170
Non-Profit			Non-Profit	Rescue Mission of El Paso	Blake W. Barrow, CEO	bwbarrow@yahoo.com 1949 West Paisano Drive El Paso, Texas 79922 (915) 532-2575

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)
Government			Government	El Paso County Juvenile Justice Center	Roger Martinez, Chief Juvenile Probation Officer	rogmartinez@epcounty.com 6400 Delta Drive El Paso, Texas 79905 (915) 849-2545 Fax (915) 849-2577
Government			Government	El Paso Department of Public Health	Michael Hill, Public Health Director	michael.hill@elpasotexas.gov 5115 El Paso Drive El Paso, Texas 79905 (915) 771-5702
Private Home Health Agency			Private Home Health Agency	Tender Care Home Health	Ann Rodriguez-McConnell	annr@tendercarehh.com 4930 Osborne Suite F El Paso, Texas 79922 (915) 581-3345
Non-Profit			Non-Profit	VNA Home Healthcare and Hospice	Joe D. Wardy, CEO & President	jwardy@vnaelpaso.com 4171 N. Mesa St., Bldg. D, Suite 500 El Paso, Texas 79902-1433 (915) 532-0888
Private Psychiatric Facility			Private Psychiatric Facility	University Behavioral Health	Selene Quintana Hammon, CEO	selene.quintana@ubhelpaso.com 1900 Denver Avenue El Paso, Texas 79902 (915) 544-4000
County Medical Associations/Societies				El Paso County Medical Society	Bruce Applebaum, MD President	epmedsoc@aol.com bapplebaum@southwestsurgeons.com 1301 Montana Avenue El Paso, Texas 79902-5530 (915) 533-0940 (915) 351-6272

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)
Regional Public Health Directors				Regional Public Health Directors	Mary Anderson, M.D.,M.P.H, Regional Medical Director Arthur G. Alvarado, R.S, M.P.H., Deputy Regional Director	Mary.anderson@dshs.state.tx.us Art.Alvarado@dshs.state.tx.us 401 East Franklin, Suite 210 El Paso, Texas 79901 Mail Code 1903 (915) 834-7675

PART THREE: SECTION II. EXECUTIVE OVERVIEW OF RHP PLAN

High-level summary of RHP healthcare environment, patient population, and health challenges: Region 15 (the "Region") faces the unique challenge of providing health care services to a high volume of indigent and immigrant patients. While the population of the Region is approximately 800,000, its healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Also, El Paso has the only Level 1 trauma center within 280 miles. Performing Providers provide substantial amounts of uncompensated care to Region 15, and have been working diligently over the past several months to develop regional and provider-specific initiatives to improve healthcare delivery to the community. In addition to residents of El Paso and Hudspeth Counties, there are a large number of non-resident patients that travel across the Mexico border to receive care. Performing Providers in our Region bear the burden of this increased usage that is neither compensated, nor recognized by State or Federal programs for the uninsured and Medicaid eligible population. In the absence of continued Medicaid supplemental funding, the healthcare providers in the community would need to reduce services to the uninsured in the community.

Region 15 participants, including Performing Providers, advocates, elected officials and community members are an association of parties that are interested in reforming the healthcare have agreed to devote the skills, time and effort necessary to accomplish the objectives set out in this RHP. As Anchor, UMC has, and will continue to work with all RHP participants to develop improvements in the delivery of healthcare services to the Region 15 community, with a focus on improving the availability and quality of care to the low-income and needy population within the Region. The Anchor welcomes input from RHP participants and continues to allow opportunity for public comment on the RHP, in accordance with Paragraphs 45(b) and (c) of the Waiver Special Terms and Conditions.

Region 15 is unique in its continued success in engaging its stakeholders and provider community. The providers (public, private, non-profit, grass-roots, state, and local entities alike) began participating at the first Region 15 RHP meeting in early March, 2012, and have continued to participate and contribute time, energy, and effort to ensure that our RHP is on-track to meet and exceed HHSC and CMS expectation.

Description of the region's current healthcare infrastructure and environment: Region 15's current healthcare infrastructure includes 10 acute care hospitals, two psychiatric hospitals, three long term acute care facilities and two specialty/rehabilitation hospitals owned and operated by the private sector (HCA & Tenet) and the government sector (county & federal). Combined, these facilities are licensed for 2,478 beds. The services provided in the Region range from Level I Trauma care, cardiovascular care, critical care, neuroscience, surgery, maternal/child care, women's services and pediatrics, to oncology, geriatrics and psychiatry. The Region 15 community is also served by several Federally Qualified Healthcare Centers and numerous private and public primary care facilities.

The Region 15 service area has an acute shortage of both primary and specialty physicians that is predicted to become substantially worse as the population grows and ages and existing

practicing physicians retire. The physician shortage is even more acute in several sections of the region which have been designated Health Professional Shortage Areas. For example, according to the Texas Medical Licensure Database (2012), the number of Family Medicine physicians currently practicing in El Paso is just 120, 58% below what is needed. The numbers are similar in Pediatrics and Internal Medicine. The same database shows that the area also suffers from a shortage of specialty physicians. In Neurology, for example, the city has only 6 neurologists, 80% below what is needed. Overall, there are approximately 116 physicians per 100,000 people in El Paso, well below the state average of 162 MDs per 100,000.

To help ameliorate the situation, the Texas Legislature approved the creation of the first Medical School on the border when it authorized Texas Tech to expand its El Paso presence from a Health Sciences Center to a full-fledged, four-year Medical School. The school opened in 2009. Additionally, Texas Tech recently established a Nursing School to complement the College of Nursing and Allied Health at UT El Paso and the nursing program at El Paso Community College.

Region 15 Mission: The RHP Participants share a common mission to improve the availability and quality of affordable healthcare services to the low-income and needy population of the Region. Each of such parties, by participating in the RHP, endeavors to improve the overall system for making available local, quality healthcare services that are affordable to the low-income population of the Region.

Goals: Region 15 seeks to affect change in the healthcare delivery system in El Paso and Hudspeth counties. Although our region is not unique in its proximity to the border, El Paso is by far the largest metropolitan area in Texas to border Mexico, which creates obstacles to the healthcare system. Undocumented immigrants represent a large portion of our uninsured and indigent population, but remain unaccounted for in State and federal assistance programs, such as Medicaid. Our goals focus on maintaining the high-quality care that our Performing Providers have historically provided, while managing the frequent use of the ED as a first healthcare resource. Uninsured and indigent patients, including the substantial immigrant population, commonly use the ED as their primary access point to the healthcare system.

As noted in the Community Needs section below, Region 15 has a severe shortage of Primary and Specialty providers. It is imperative that our Region devote resources to growing the specialist presence and scope of services offered in the community. Currently, many patients are forced to travel to Dallas, Houston, and outside the state to find the specialty care they require.

As with many regions throughout Texas, Region 15 has a dearth of behavioral healthcare services available in the community. Behavioral health facilities currently operate above-capacity, and Performing Providers in the Region continue to struggle to provide adequate behavioral healthcare to patients.

To address these concerns, Region 15 endeavors to:

- Increase access to primary care through the expansion of medical homes, primary care clinics, and more effective care navigation upon discharge;

- Provide the full continuum of healthcare services, including all aspects of healthcare, such as wellness, preventative care, emergent care, disease management, palliative and hospice care;
- Better manage patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, Epilepsy, Dementia, and Renal disease to help prevent unnecessary readmission and get patients the care they need to prevent, self-manage, and address in an appropriate setting;
- Provide patient education to ensure the population is accessing the right care in the right setting;
- Overcome language, socio-economic, and monetary barriers to accessing healthcare resources in the region;
- Increase the number of specialist and scope of services offered in the community.
- Address the issues of Diabetes and Obesity, as they represent major health concerns in Region 15; and
- Increase patient satisfaction through delivery of high-quality, effective healthcare services.

Expected Outcome over the 5 years of the Waiver: Region 15's performing providers expect to realize improvements in the overall healthcare delivery system, including serving uninsured and indigent patients that do not currently have access to the healthcare system. We also expect that more patients will be served in the community through increased access to primary and specialty care. Each entity has produced a basket of projects that include facility-specific projects and regionally-focused projects that are aimed at improving the landscape of healthcare in our community.

As designated in the Community Needs section below, Access to Primary and Specialty/Secondary care is a huge focus in our Region, and many providers have chosen to implement projects in those areas. Chronic Disease, and Diabetes in particular are an area for improvement in our Region, and UMC, Texas Tech, and HCA have all developed projects to address this ongoing concern. Region 15 has a high percentage of the population that are in the "overweight" and "obese" categories on many national scales. This epidemic is a major strain on the healthcare delivery systems, as an unhealthy weight leads to serious complications with existing conditions, and can also be a factor in developing certain Chronic Diseases, such as Diabetes, Asthma, and CHF.

Behavioral health resources in the Region do not have the resources, staffing, or funding necessary to meet the significant behavioral healthcare needs in the community. Emergence Healthcare Network, the El Paso Psychiatric Hospital, and others have taken great strides over the past decade in providing increased services. Emergence has proposed creating a crisis stabilization unit, a crisis respite unit, as well as expanding behavioral health services and providers throughout the community. UMC is also developing a project to implement a psychiatric liaison service to reduce the time a patient will wait to receive crucial behavioral health services.

Summary of Categories 1-2 Projects

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Category 1: Infrastructure Development			
138951211.1.1 Category 1.9.1 Expanded Residency - University Medical Center of El Paso (UMC) TPI 138951211	This project will establish an ongoing rotation for new specialty residencies and fellowships and additional residents based at Texas Tech University Health Sciences Center (Texas Tech) in El Paso.	138951211.3.1 138951211.3.18 138951211.3.19 OD-14 Workforce Projects TSC Resident and Fellow Program Non-Standalone Measures: IT-14.6; IT-14.7; IT-14.8	$ 13,184,867
138951211.1.2 Category: 1.10.2 Electronic Medical Records University Medical Center of El Paso (UMC) TPI 138951211	Gaining access to national databases for Trauma and Surgical cases will save time, increase patient satisfaction, and allow practitioners to provide more holistic diagnoses and treatment. The implementation of robust EMR and data collecting systems will provide the infrastructure to improve patient care by increasing compliance with evidence-based standards of care and decrease untoward events.	138951211.3.2 OD-4: Potentially Preventable Complications and Healthcare Acquired Conditions IT-4.3: Catheter-associated Urinary Tract Infections (CAUTI) rates.	$ 8,327,284
138951211.1.3 Category: 1.1.1 Establish More Primary Care Clinics UMC NHC – Crossroads - University Medical Center of El Paso (UMC) TPI 138951211	Expand, increase, and improve access to primary and urgent care services within the RHP Region, by opening a new Primary Care Clinic serving the Westside of El Paso.	138951211.3.3 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores	$ 13,184,867
138951211.1.4 Category: 1.1.2 Establish More Primary Care Clinics UMC NHC – East - University Medical Center of El Paso (UMC) TPI 138951211	This project will expand access to primary and urgent care in the RHP Region, and more specifically the East area of El Paso County by relocating and expanding the Montwood Clinic to a much larger site offering many additional services including additional primary care staff, evening and	138951211.3.4 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores	$ 13,184,867

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	Saturday hours, Women's Health Services including ultrasound, a regional laboratory and a pharmacy.		
138951211.1.5 Category: 1.1.2 Expand Existing Primary Care Capacity – NHCs Ysleta and Fabens - University Medical Center of El Paso (UMC) TPI 138951211	This project will expand access to primary and urgent care in the RHP Region, and more specifically El Paso County. UMC will expand primary and urgent care staffing, services and hours at two existing Neighborhood Health Centers at Ysleta and Fabens helping them to become minor hub sites.	138951211.3.5 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores	$ 11,103,046
138951211.1.6 Category: 1.9.3 Establish Nurse Residency and Simulation Lab - University Medical Center of El Paso (UMC) TPI 138951211	Establish Nurse Residency and Simulation Lab for Graduate Nurses to focus on specialty care training, reinforce didactic content, learn and practice skills, and develop critical thinking, decision making and organizational skills, while providing holistic patient care.	138951211.3.6 (IT-14.6) 138951211.3.20 (IT-14.7) 138951211.3.21 (IT-14.8) OD-14 Workforce Projects IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA), or medically underserved area (MUA) IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey	$ 10,409,105
138951211.1.7 Category: 1.10.3 Enhance Performance Improvement and Reporting Capacity at UMC	This project will allow us to document the improvement in the quality of care at its UMC neighborhood health centers by upgrading the EMR system to be	138951211.3.7 OD – 12 Primary Care and primary Prevention	$ 5,551,523

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
NHCs - University Medical Center of El Paso (UMC) TPI 138951211	able to electronic prescribe medications, meeting meaningful use standards and tracking HEDIS measures for higher quality care and better documentation.	IT-12.6 Other Outcome Improvement Measure: Hemoglobin Alc Measurement: reduce Hemoglobin Alc Measurements in patient discharged to the NHCs to below 8% within 1 year.	
138951211.1.8 Category: 1.9.3 Inserting Behavioral Health Trained Practitioners into a Non-Behavioral Health Setting. Psychiatric Nurse Liaison Service - University Medical Center of El Paso (UMC) TPI 138951211	This project will evaluate the need to have Psychiatric trained nurses and social workers at UMC for patients undergoing medical/surgical treatment that also have a psychiatric condition. It will also review current hours of psychiatrist consultative service in the ED and on the inpatient unit. A program will be established to provide round the clock psychiatric care to our medical patients in need.	138951211.3.8 OD-11 Addressing Health Disparities in Minority Populations IT-11.5; IT-3.1: All-cause 30-day readmission rate for patients enrolled in the Psychiatric Liaison Service	$ 9,715,165
094109802.1.1 Category: 1.1.4 Physician and Mid-Level Recruitment and Training - HCA Las Palmas Del Sol TPI 094109802	This project will increase recruitment and training of physicians and mid-level practitioners. Training will entail partnering with educational institutions in the area to increase the hands-on training for physicians and mid-level practitioners.	094109802.3.1 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$7,846,229
094109802.1.2 Category: 1.1.1 Outpatient Women's Imaging Services Expansion HCA Las Palmas Del Sol TPI 094109802	This project will expand the availability of the Women's Service Resource Centers and streamline processes within those centers, such as training current staff to be able to provide laboratory services in existing resource centers, while looking at the option of hiring a part-time phlebotomist. It would also encompass expanding hours to include Saturdays and community-based awareness and	094109802.3.2 OD 8 – Perinatal Outcomes IT 8.2 Percentage of Low Birth-weight births (CHIPRA/NQF #1382)	$6,923,143

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	education opportunities.		
094109802.1.3 Category: 1.3.1 Develop Diabetes Management Registry Project Replacement HCA Las Palmas Del Sol TPI 094109802	HCA Las Palmas Del Sol will establish a chronic disease registry for patients with diabetes, so that their care can be tracked and managed within the local community. We will investigate the need to track and manage the large population with pre-diabetes. The registry, CDEMS, is used by community health centers, primary care practices, rural clinics, hospitals, and quality improvement projects across the United States and in Canada, India, Haiti, and South Africa.	094109802.3.3 OD-3: Potentially Preventable Re-Admissions—30 day Readmission Rates IT-3.3: Diabetes 30 day readmission rate	$6,461,600
094109802.1.4 Category: 1.7.1 Psychiatric Telemedicine - HCA Las Palmas Del Sol TPI 094109802	Expand coverage through the use of a contracted vendor to provide for the evaluation of acute behavioral health patients in the Emergency Departments. A tele-psychiatric consultation could potentially have a turn-around disposition time of about an hour. The availability of psychiatric consultation in the ED through the tele-psychiatry model would provide immediate access to psychiatric services currently not available to the patient, provide needed guidance to the ED physicians, and facilitate the management of psychiatric patients through the ED.	094109802.3.4 OD-2: Potentially Preventable Admissions IT-2.4: Behavioral Health/Substance Abuse (BH/SA) Admission Rate	$8,307,772
094109802.1.5 Category: 1.9.1 Expand Specialty Care HCA Las Palmas Del Sol TPI 094109802	LPDS will perform and implement a community needs assessment to determine specialties that are underserved at LPDS. LPDS will initiate recruitment of two	130601104.3.6 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient	$7,384,686

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
REPLACEMENT PROJECT FOR DELETED 094109802.2.2	specialists and staff as needed and formation or expansion of two specialty clinics to better meet the needs of the El Paso community. LPDS will begin expanding specialty provider clinic hours to increase the availability of specialist services.	satisfaction scores	
130601104.1.1 Category: 1.1.2 Expand Primary Care Access - Providence Memorial Hospital TPI 130601104	This project will expand hours of coverage, locations, and staffing of Urgent Care Centers to ensure the Medicaid and uninsured patient population has access to the appropriate venue for care. Increased access to primary care will help address a substantial need in the community for increased access to primary care. This will promote the appropriate level of care in the appropriate setting.	130601104.3.1 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$8,396,338
130601104.1.2 Category: 1.4.4 Enhance Interpretation Services and Culturally Competent Care - Providence Memorial Hospital TPI 130601104	This project will improve the cultural competency of the staff and competency in assessment of health literacy to improve effective communication amongst Tenet's health care providers.	130601104.3.2 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$4,617,986
130601104.1.3 Category: 1.9.1 Expand Specialty Care Capacity - Providence Memorial Hospital TPI 130601104	This project will entail the performance and implementation of a community needs assessment and identification of the formation of a specialty clinic based on the needs of the community.	130601104.3.3 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$6,717,071
196829901.1.1 Category: 1.1.2 Expand Primary Care Access - Sierra Providence East Medical Center TPI 196829901	This project will expand hours of coverage, locations, and staffing of Urgent Care Centers to ensure the Medicaid and uninsured patient population has access to the appropriate venue for care.	196829901.3.1 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient	$4,714,113

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	Increased access to primary care will help address a substantial need in the community for increased access to primary care. This will promote the appropriate level of care in the appropriate setting.	satisfaction scores	
196829901.1.2 Category: 1.4.4 Enhance Interpretation Services and Culturally Competent Care - Sierra Providence East Medical Center TPI 196829901	This project will improve the cultural competency of the staff and competency in assessment of health literacy to improve effective communication amongst Tenet's health care providers.	196829901.3.2 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$2,592,762
196829901.1.3 Category: 1.9.1 Expand Specialty Care Capacity - Sierra Providence East Medical Center TPI 196829901	This project will entail the performance and implementation of a community needs assessment and identification of the formation of a specialty clinic based on the needs of the community.	196829901.3.3 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$3,771,289
084597603.1.1 Category: 1.9.3 A Proposal to Increase Access to Ocular care to an Underserved Population - TEXAS TECH HS CTR FAMILY MED TPI 084597603	This project will address the Region's inability to meet the ocular care needs of its patients, particularly the indigent and Medicaid populations. The project will recruit four additional ocular care providers (two ophthalmologists and two additional therapeutic optometrists) along with the required support personnel, and develop an electronic referral system linking primary care to the ophthalmology providers to facilitate referrals.	084597603.3.1 084597603.3.2 084597603.3.3 OD-11 Addressing Health Disparities in Minority Populations IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity IT-11.4 Improve patient satisfaction IT-11.6 Other outcome improvement target.	$7,537,460
084597603.1.2 Category: 1.3.1 A proposal to establish an enterprise wide Chronic	This project will develop the resources and infrastructure to design, build, and maintain patient registries as an enterprise	084597603.3.4 OD-1 Primary Care and Chronic Disease Management	$3,526,287

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Disease Management Registry - TEXAS TECH HS CTR FAMILY MED TPI 084597603	priority available as a resource to support any Department that identifies a need. By developing these resources centrally, we can be assured that disease conditions treated by multiple departments are recorded in a uniform manner for comparison and reporting The Texas Tech Physicians of El Paso is a 225 member provider group serving the PLFSOM.	IT-1.11 Diabetes care: BP control	
084597603.1.3 Category: 1.9.3 A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network - TEXAS TECH HS CTR FAMILY MED TPI 084597603	The overall goal of this project is to address a critical lack of access to neurology providers in our region and to address the geographic distribution of these providers to further improve access.	084597603.3.5 OD-11 Addressing Health Care Disparities in Minority Populations IT-11.1 Improvement in Clinical Indicator in identified disparity group: We propose to utilize a metric which reflects a decrease in the rate of reoccurrence of seizures in a Hispanic population with epilepsy followed in our neurology program.	$13,664,389
084597603.1.4 Category: 1.9.1 The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC) - TEXAS TECH HS CTR FAMILY MED TPI 084597603	The University Breast Care Center began operation in 1994 providing comprehensive breast care for the Region's medically indigent women with breast disease. Currently twenty-five (25%) of patients seen there have no third party insurance, and the majority of the remainder have only Medicaid. Collectively, the Center provides care for approximately 1/3 of the women in the El Paso area with a new diagnosis of breast cancer, and is the primary provider of care to women with breast disease who lack health insurance.	084597603.3.6 OD-10 Quality of Life / Functional Status IT-10.1 Quality of Life	$4,990,49

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
084597603.1.5 Category: 1.9.2 Expanding access to surgical services to a Hispanic population - TEXAS TECH HS CTR FAMILY MED TPI 084597603	This project will address a critical shortage of surgical providers in our region and to address the geographic distribution of these providers via three strategies: 1) recruit surgeons and surgical physician extenders to the region; 2) expand the number of sites offering outpatient general surgery clinic services, and 3) streamline the referral process from primary care providers to the surgical program by creating and implementing an electronic referral system.	084597603.3.7 OD-6 Patient Satisfaction IT-6.2 Other outcome improvement target	$4,415,618
084597603.1.6 Category: 1.1.4 Expansion of Pediatric primary care by providing Health Periodicity Exams in conjunction with a visit to an acute care walk in clinic TEXAS TECH HS CTR FAMILY MED TPI 084597603	The goal of this project is to increase the number of children who receive appropriate health periodicity exams as defined by the American Academy of Pediatrics Bright Futures Recommendations and are current in their immunization status.	084597603.3.8 OD-11 Addressing Health Disparities in Minority Populations IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider	$1,784,782
084597603.1.7 Category: 1.9.1 Increased Access to Minimally Invasive Surgical (MIS) Services For Low Income and Hispanic Patients - TEXAS TECH HS CTR FAMILY MED TPI 084597603	The overall goal of this project is to increase the availability of minimally invasive surgical techniques to a Hispanic and low income population by leveraging our existing faculty resources to develop an accredited two year fellowship program in Minimally Invasive Surgery (MIS).	084597603.3.9,084597603.3.10 084597603.3.11 OD-14 Workforce Projects IT-14.6 Percent of trainees who have spent at least 5 years living in a HPSA /MUA IT-14.7 Percent of trainees who report that they plan to practice in HPSA or MUA based on a systematic survey IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on on a systematic survey.	$2,425,428

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
084597603.1.8 Pass 2 Category: 1.9.1 Expand Specialty Care: A proposal to expand a Child Psychiatry Fellowship Program- TEXAS TECH HS CTR FAMILY MED TPI 084597603	The overall goal of this project is to address a critical lack of behavioral health providers in our region. We propose to accomplish this through the expansion of an existing 2 year child fellowship program from one fellow per year to two fellows per year.	084597603.3.15, 084597603.3.16, 084597603.3.17 OD-14 Workforce Projects IT-14.6 Percent of trainees who have spent at least 5 years living in a HPSA /MUA IT-14.7 Percent of trainees who report that they plan to practice in HPSA or MUA based on a systematic survey IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey	$863,919
127376505 1.1 Category 1.13.1 Extended Observation Unit Emergence Health Network 127376505	EHN is proposing to develop psychiatric emergency services as an alternative to inappropriate systems of care (i.e., jail, local hospitals, and emergency departments). The proposed project to address this need is an Extended Observation Unit ("EOU").	127376505 3.1 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization as it correlates with the utilization of the EOU. The expected outcome is that there will be a reduction in the utilization of emergency departments and criminal justice system as individuals will receive the needed care in the EOU.	$19,800,816
127376505 1.2 Category 1.14.1 Expand Behavioral Health Providers Emergence Health Network 127376505	EHN is proposing to expand the capacity and access to behavioral health care by increasing the number of behavioral health providers in the community.	127376505.3.2 OD-6 Patient Satisfaction IT-6.1 The goal of expanding behavioral health providers is to remove barriers and increase access to behavioral health services in the community. The project will enhance EHN's current provider base in order to increase patient choice with culturally and linguistically diverse providers, thus having a positive effect on patient	$2,799,238

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
		satisfaction.	
127376505 1.3 Category 1.13.2 Crisis Stabilization for IDD Population Emergence Health Network 127376505	EHN is proposing to develop a crisis stabilization unit for individuals with intellectual and developmental disabilities ("IDD") and/or co-occurring serious and persistent mental illness (SPMI). EHN will explore the development of an evidenced-based long-term crisis intervention and stabilization services model, START: Systematic, Therapeutic, Assessment, Respite, and Treatment.	127376505.3.3 OD-10 Quality of Life / Functional Status IT-10.1 Quality of Life to improve symptoms and functioning. Quality of life is evidenced by the START Program's national statistic which includes its current retention rate for home placements of 95%, two-day reduction in average length of stay per hospitalization, and improvement in mental health outcome measures and comparisons.	$3,581,755
065086301.1.1 Category: 1.5.2 Border Public Health Interest Group - City of El Paso Department of Public Health TPI 065086301	The City of El Paso Department of Public Health proposes a three academic institution collaborative research interest group which will collect and analyze REAL data to describe regional/local health problems and prescribe appropriate policy/program interventions.	065086301.3.1 OD-11: Addressing Health Disparities in Minority Populations IT-11.3 Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity: Increase number of Minorities who obtain annual flu vaccine, Tdap booster, and lipid screening	$4,309,791
065086301.1.2 Category: 1.5.3 El Paso Community Health Atlas - City of El Paso Department of Public Health TPI 065086301	Appropriate delivery of care and health care planning requires the measurement of biomarkers as a way to (1) identify risk factors for certain conditions; (2) track trends in prevalence over time ;(3) identify health care needs in population groups and areas; (4) prioritize programs / strategies to	065086301.3.2 OD-11: Addressing Health Disparities in Minority Populations IT-11.6 (DY 4-5): Other Outcome Improvement Target (TBD)	$3,760,225

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	meet needs; and (5) evaluate the impact of programs/interventions, i.e., health promotion and service delivery interventions. In general, this has not been done in the United States as a pillar of our public health initiatives. To draw a complete and accurate picture of health status of El Pasoans, data are needed from health system users and non-users, i.e., those within and outside the health care system.		
065086301.1.3 Category: 1.8.7 Expansion of Oral Health Services - City of El Paso Department of Public Health TPI 065086301	The City of El Paso Department of Public Health proposes to expand access to dental care for low income children in the El Paso area by acquiring, outfitting, staffing, and deploying a mobile dental clinic to underserved areas/populations outside of the current catchment area of the department's fixed-site Rawlings Dental Clinic.	065086301.3.3 OD-7: Oral Health IT-7.2 Cavities: Percentage of children with untreated dental cavities	$4,921,967
065086301.1.4 Category: 1.10.2 Enhance Improvement Capacity Through Technology - City of El Paso Department of Public Health TPI 065086301	To improve the health of El Paso area residents and visitors, this project will enhance dispatch performance and reporting to decrease dispatch times. This will ensure the public receives prompt Emergency Medical Care for the region. These new response times will allow for improvements to be tracked and result in a positive patient outcome.	065086301.3.4 OD-9: Right Care, Right Setting IT-9.4 Other Outcome Improvement Target	$5,793,499
065086301.1.5 Pass 2 Category: 1.5.2 Implement data sharing agreements to aid in health disparity evaluation City of El Paso Department of Public Health	The aim of this project is to expand collection and integration of regionally relevant healthcare data for border care not presently gather by the Texas Health Information Exchange. This	OD – Primary Care and primary Prevention 065086301.3.5 – IT-12.1 Breast Cancer Screening 065086301.3.6 – IT-12.3 Colorectal Cancer Screening 065086301.3.7 – IT-12.4	$431,961

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
065086301	project is designed to gather and integrate patient centered data for regional comparative effectiveness research in define populations living in our region	Pneumococcal Vaccination	
Category 2: Program Innovation and Redesign			
138951211.2.1 Category: 2.6.4 The Salvation Army, Redshield Health A Holistic Wellness Program for the Homeless - University Medical Center of El Paso (UMC) TPI 138951211	The Salvation Army's health and wellness program will be designed to provide primary and preventive healthcare to residents living at the shelter by contracting with and placing VNA nurses in the shelter. This project will also encompass a wellness program that will provide for nutritious food, education, and fitness/wellness for the families in the shelter. The focus with the typical resident here will include chronic conditions, specifically (but not limited to) diabetes and obesity.	138951211.3.9 OD-11 Addressing Health Disparities in Minority Populations IT-11.5 – (IT-3.1) PPR 30 Day Readmissions for target homeless population discharged to the Salvation Army from UMC and residents enrolled in VNA Shelter Service	$ 9,021,225
138951211.2.2 Category 2.7.6 Rescue Mission / VNA Shelter Program for the Homeless - University Medical Center of El Paso (UMC) TPI 138951211	The Rescue Mission's Nursing Program will be designed to provide primary and preventive healthcare to residents living at the Rescue Mission, a homeless shelter in El Paso. This program also delivers education and support to empower them to gain control of their lives through disease management, medication compliance, appropriate diet and nutrition, and lifestyle changes. VNA will provide the nursing and support services for the Rescue Mission's residents to prevent them from using the County Hospital or other EDs for their primary care or for non-emergent care needs. The Shelter will	138951211.3.10 OD-11 Addressing Health Disparities in Minority Populations IT-11. 6(PPR 30 Day Readmissions for target homeless population discharged to the Rescue Mission with chronic conditions that include but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension)	$ 5,551,523

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	provide the space and VNA will provide the nursing and support staff where we will be able to monitor the chronic health conditions of those residing at the shelter.		
138951211.2.3 Category: 2.9.1 Discharge Facilitation/Navigation To High-Risk Patients - University Medical Center of El Paso (UMC) TPI 138951211	This project will identify high-risk patients based on chronic conditions and history of readmissions, and create/amend staff positions to facilitate the discharge of these patients to include RNs, physicians, case managers, social workers, and other appropriate practitioners in the hospital setting. The project will specifically target patients with diabetes, renal disease, history of stroke, obesity, and other populations with a history of readmissions.	138951211.3.11 OD-11 Addressing Health Disparities in Minority Populations IT-11.5 Other Outcomes Target (IT-3.1) 30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program)	$ 12,490,927
138951211.2.4 Category 2.1.1 Enhance/Expand Medical Homes: NHC Medical Home Expansion - University Medical Center of El Paso (UMC) TPI 138951211	This project will increase coordination of patient's care in a medical home environment. The project will seek to obtain Medical Home Certification for each of the Neighborhood Health Clinic sites, and create a patient registry.	138951211.3.12 OD-11 Addressing Health Disparities in Minority Population IT-11.5 Select any other Category 3 outcome IT-3.12: Patients discharged from UMC with principal diagnoses that are discharged to the UMC NHC Medical Homes. 30 day readmission rate	$ 11,796,986
138951211.2.5 Category: 2.2.1 Expand Chronic Care Management Model Programs & Services at UMC NHCs - University Medical Center of El Paso (UMC)	Redesign the outpatient delivery system to coordinate care for patients with chronic diseases and improve patient outcomes. Program will target diabetic patients with an emphasis on those who are post discharge.	138951211.3.13 OD-11 Addressing Health Disparities in Minority Populations IT-11.5 / IT-3.12 PPR 30 Day Readmission for Diabetes patients who are discharged to	$ 7,633,344

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
TPI 138951211		UMC NHC (target population)	
138951211.2.6 Category: 2.11.2a Conduct Medication Management – Establish a Coumadin Clinic at UMC Neighborhood Health Centers - University Medical Center of El Paso (UMC) TPI 138951211	Establish a Coumadin Clinic at UMC NHCs. Services of the UMC Coumadin Clinic will include: establishment of a medical home, patient assessment, monitoring of anticoagulation, warfarin dosage adjustment, medication education and management, patient education including nutrition counseling and self-management and follow-up care. Improve overall patient health status post stroke or coronary artery disease event, Improve patient management of Coumadin intake; provide monitors for patients to self-test at home to monitor their blood coagulation.	138951211.3.14 OD-11 Addressing Health Disparities in Minority Populations IT-11.5 (IT-3.12) Coronary Artery Disease and Stroke 30 day readmission rate for UMC patients discharged to the UMC Neighborhood Health Centers	$ 10,409,106
138951211.2.7 Category: 2.10.1 Complete Hospice Care for Uncompensated Patients - University Medical Center of El Paso (UMC) TPI 138951211	UMC will contract with Hospice of El Paso to transition all hospice appropriate uncompensated patients into their services. These patients also include hospice-appropriate patients needing acute care and ventilator support.	138951211.3.15 OD –13 Palliative Care IT-13.4 Proportion admitted to the hospital in the last 30 days of life (NQF 0213)	$ 9,021,225
138951211.2.8 Category: 2.12.2 Develop Surgery Guidebook for Patients and Corresponding Nurse Advice-Line - University Medical Center of El Paso (UMC) TPI 138951211	This project will provide surgical support for UMC's surgical patients including an educational guidebook, resources for pre-surgery, intra-surgery, post-surgery, discharge and follow-up. The project will additionally create a 24/7 nurse advice-line for surgical patients as a resource for our staff to contact surgical patients and for them to access with questions and concerns at any time in the process.	138951211.3.16 OD-11 Addressing Health Disparities in Minority Populations IT-11.5 (IT-3.12) Other Outcome Improvement Target PPR 30 Day Readmission Rate in UMC patients enrolled in program	$ 8,327,284

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
138951211.2.9 Pass 2 Category: 2.8.1 Applying LEAN principles to Hospital Throughput to improve Emergency Department throughput and reduce admission process times - University Medical Center of El Paso (UMC) TPI 138951211	This project will improve throughput within the ED by implementing LEAN manufacturing principles to a healthcare delivery system at UMC to improve process flow. Expected outcome is to improve ED throughput by implementing systemic actions to improve the process for admissions occurring in the ED, reducing the total LOS for admissions originating in the ED, and improving Customer Satisfaction scores for the ED. UMC will test this process weekly.	138951211.3.17 OD-9 Right Care, Right Setting IT-9.4 Other Outcome Improvement Target; Overall wait times for ED patients, Reduction in LWBS rates for ED patients	$ 3,234,223
0941090802.2.1 Category: 2.12.2 Streamline Discharge Process / ED Management Services - HCA Las Palmas Del Sol TPI 0941090802	This project will establish case management and coordinated discharge planning processes to identify top chronic conditions that are common causes of avoidable readmissions and develop strategies to reduce readmissions in those specific populations. ED discharge is a prime target for improvement in the delivery of effective discharge instructions, follow-up care recommendations, referrals to community providers or resources, matching patients with appropriate community-based resources, and increasing patient satisfaction.	094109802.3.5 OD-3: Potentially Preventable Re-Admissions—30 day Readmission Rates IT-3.1: All cause 30 day readmission rate	$5,076,972
PROJECT DELETED AND REPLACED WITH 0941090802.1.5			
0941090802.2.3 Category: 2.4.3 Evaluate Hospitalist Model HCA Las Palmas Del Sol TPI 0941090802	This project will research, design, and implement a hospitalist model to increase productivity and access to care for patients, involving both physicians and mid-level providers. This current lack	094109802.3.7 OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient	$4,615,429

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	of access to primary care is causing increased length of stay and decreased patient satisfaction.	satisfaction scores	
0941090802.2.4 Category: 2.2.2 Congestive Heart Failure Clinic - HCA Las Palmas Del Sol TPI 0941090802	This project will implement a Chronic Care Management Model relating to patients with Congestive Heart Failure (CHF). The CHF Initiative will utilize a multi-disciplinary expert health professional team to deliver optimal patient care via current evidence-based guidelines and the development and implementation of new initiatives to meet service delivery gaps. This will enable the hospital to collaborate with community-based home-health agencies who will assist in the prevention of unnecessary readmissions.	094109802.3.8 OD-3: Potentially Preventable Re-Admissions—30 day Readmission Rates IT-3.2: Congestive Heart Failure 30 day readmission rate	$8,307,772
130601104.2.1 Category: 2.12.2 Implement/Expand Care Transitions Programs - Providence Memorial Hospital TPI 130601104	This project will involve identification and targeting of patients with the highest risk of readmission, to include discharge planning assessment and intervention, development of tools that case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days. The intent of this project is to support a safe, effective, and efficient transition to post-acute care.	130601104.3.4 OD-3: Potentially Preventable Re-Admissions—30 day Readmission Rates (PPRs) IT-3.1: All cause 30 day readmission rate	$6,717,071
196829901.2.1 Category: 2.12.2 Implement/Expand Care Transitions Programs - Sierra Providence East Medical Center TPI 196829901	This project will involve identification and targeting of patients with the highest risk of readmission, to include discharge planning assessment and intervention, development of tools that case managers to identify and target those patients	196829901.3.4 OD-3: Potentially Preventable Re-Admissions—30 day Readmission Rates (PPRs) IT-3.1: All cause 30 day readmission rate	$3,771,290

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	at risk for readmission to the hospital within 30 to 60 days. The intent of this project is to support a safe, effective, and efficient transition to post-acute care.		
084597603.2.1 Category: 2.1.3 The Development of a Primary Care Medical Home in a Health Professions Shortage Area TEXAS TECH HS CTR FAMILY MED TPI 084597603	The purpose of this project is to establish the Department of Family Medicine Kenworthy Clinic as a Primary Care Medical Home. By doing so, we will improve overall chronic disease management and promote health outcomes in the target population.	084597603.3.12 084597603.3.13 084597603.3.14 OD-Primary Care and Chronic Disease Management IT-1.12 Diabetes care: Retinal eye exam IT-1.13 Diabetes care: Foot exam IT-1.14 Diabetes care: Microalbumin/Nephropathy	$4,104,111
127376505 2.1 Category 2.13.1 Crisis Residential Unit Emergence Health Network 127376505	EHN is proposing to develop psychiatric emergency services as an alternative to inappropriate systems of care (i.e., jail, local hospitals, and emergency departments). The proposed project to address this need is a Crisis Respite Unit ("CRU").	127376505.3.4 OD-9 Right Care/Right Setting IT-9.2 ED appropriate utilization. The expected outcome is that there will be a reduction in the utilization of emergency departments as individuals will receive the needed care in the CRU.	$16,527,000
127376505 2.2 Pass 2 Category: 2.13.2 Expand Behavioral Health/Substance Abuse Training for the Workforce Emergence Health Network 127376505	Implementation of evidence-based trainings will include Dialectical Behavioral Therapy (DBT), Cognitive Processing Therapy (CPT), and "Recovery Innovations" curriculum. EHN believes implementing these trainings/curriculums will result in improved patient outcomes. The goal of this project is to expand behavioral health/ substance abuse training for Licensed Practitioners, EHN staff and community stakeholders. The current behavioral health care system in El Paso, TX has limited treatment intervention options	127376505.3.5 OD-10 Quality of Life/Functional Status IT- 10.1 Quality of Life	$848,706

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
	for the targeted population.		
2981854201.2.1 Pass 2 Category: 2.4.3 Redesign to improve Patient Experience: Creation of a Pediatric Hospitalist Program – El Paso Children's Hospital TPI 2981854201	Under this project, El Paso Children's Hospital will design, and implement a pediatric hospitalist model to increase productivity and access to care for patients, involving primary pediatric community physicians.	2981854201.3.1 OD-6 Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$1,320,954

PART FOUR: SECTION III. COMMUNITY NEEDS ASSESSMENT

The needs and resources in Region 15 are widely disparate from that of Texas as a whole. Local solutions are the best way to increase accountability, transparency, improve delivery systems, improve capacity, and align the Regional healthcare system, as anticipated by the Waiver. Region 15 is comprised of El Paso County and Hudspeth County, with El Paso representing the Regions largest metropolitan area.

El Paso County covers 1,012 square miles and currently has a population of 800,647. El Paso County is the 6th most populous county in Texas and is expected to continue to grow in the next five years.[1] The average per capita personal income in El Paso County is only $28,071, compared to the Texas average of $37,809. About 24.6% of El Paso County population lives below the federal poverty level, which for 2010 is $10,830 for a one person household, and $22,050 for a family of four. El Paso County has a poverty rate is above the state-wide average of 17.9%.[2] In addition, nearly one-third of El Paso County's children live in poverty. Approximately 33.8% of El Paso County children under the age of 18 were living with families below the federal poverty level. In 2008, 6% of Texas residents receiving Temporary Assistance for Needy Families reside in El Paso County, and El Paso County has approximately 4.6% of the State's Medicaid eligible residents.[3]

Hudspeth County comprises 4,571 square miles in west Texas, and is classified as a rural county.[4] Hudspeth County has about 3,500 residents. In 2010 the per capita income is $11,465 per year, and 46% of the population was below poverty level.[5] The population is made up of almost 30% aged 18 and under, 14% over 65, and about 80% with Hispanic or Latino origins.[6] Due to the large Hispanic and Latino populations, about 75% of the Hudspeth County population speaks a language other than English in the home.[7]

The Texas indigent population is extremely high, and Texas leads the nation in persons without health insurance at nearly 26% of its population, well above the national average rate of 16.3%.[8] In addition to the state-wide healthcare crisis, Region 15 faces challenges and burdens above the State average in many healthcare-related areas. Over 28% of El Paso residents and over 41% of Hudspeth County residents under 65 are uninsured.[9] In fact, Hudspeth County

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1 Texas Department of State Health Services, Health Facts Profile for El Paso County, 2008 Data, *available at* http://www.dshs.state.tx.us/chs/cfs/2008/2008-Health-Facts-Profiles-for-Texas/; Texas Department of State Health Services, Population Projections, *available at* http://www.dshs.state.tx.us/chs/popdat/ST2015.shtm.

2 U.S. Census Bureau, Small Area Income and Poverty Estimates, 2010 Data, *available at* http://www.census.gov/cgi-bin/saipe/saipe.cgi.

3 Texas Department of State Health Services, Health Facts Profile for El Paso County, 2008 Data, *available at* http://www.dshs.state.tx.us/chs/cfs/2008/2008-Health-Facts-Profiles-for-Texas/.

4 U.S. Census Bureau, 2010 Census Data, *available at* http://quickfacts.census.gov/qfd/states/48/48229.html.

5 U.S. Census Bureau, 2010 Census Data, *available at* http://quickfacts.census.gov/qfd/states/48/48229.html.

6 U.S. Census Bureau, 2010 Census Data, *available at* http://quickfacts.census.gov/qfd/states/48/48229.html.

7 U.S. Census Bureau, 2010 Census Data, *available at* http://quickfacts.census.gov/qfd/states/48/48229.html.

8 U.S. Census Bureau, 2010 Census Data, *available at* http://2010.census.gov/2010census/data/.

9 Texas Medical Association, 2010 data, *available at* http://www.texmed.org/template.aspx?id=5517; U.S. Census Bureau, 2010 Census Data, *available at* http://2010.census.gov/2010census/data/; *see also* Hudspeth County Herald, Hudspeth Leads State in Rate of Uninsured, September 7, 2012, *available at* http://hudspethcountyherald.com/hudspeth-county-leads-state-in-rate-of-uninsured.

leads the entire nation in uninsured as a percentage of the total population.[10] Over 47% of children in El Paso County under the age of 18 are enrolled in Medicaid.[11] With a very high percentage of non-citizen immigrants, the Region has a high concentration of indigent residents. These circumstances have created a need for the healthcare providers in the community to work together to share the burden of providing care to the low-income and needy residents and allow for greater participation in State and federal programs that provide funding for the provision of health care services to the indigent.

In early 2011, in order to more effectively compile community needs and to conduct a thorough analysis of the health care needs specific to the community, a broad cross-section of community members met in workgroups throughout Region 15, and surrounding communities in New Mexico and the Juarez area. The Blue Ribbon Committee ("BRC"), established by The El Paso del Norte Health Foundation and the City of El Paso, was formed with the goal of analyzing the healthcare needs of residents in El Paso, Hudspeth, and the surrounding communities. In total, over 150 participants gathered from this area including health care providers such as Texas Tech, the Sierra Providence Health Network, UMC El Paso, the Texas Department of Aging and Disability Services, local clinics and imaging centers, Chiropractic service providers, Centro San Vicente, the Ben Archer Health Center, New Mexico State University, and many others. In addition to healthcare professionals and providers, the BRC was comprised of non-profits, health insurance companies, local fire department officials, elected officials, Hudspeth and El Paso County representatives, media outlets such as the El Paso Times, and financial sector representatives.

The BRC incorporated its findings in a Needs Assessment Report that details the Region's health care problem areas and possible community solutions, which is provided in full as an addendum to this RHP plan.[12] The BRC represented areas in Texas, New Mexico and Mexico that have highly integrated healthcare resources, and often utilize specialty providers in other communities. For the purposes of this community needs assessment under the Waiver, Region 15 has limited the assessment and utilized data and information pertinent to El Paso and Hudspeth communities, as they comprise Region 15. Through analysis of the BRC Report, Region 15 has determined that particularly underserviced areas of healthcare in the community include Primary Care, Specialty and Secondary Care, Diabetes, Obesity, and Behavioral Healthcare. Following are detailed findings from the workgroups for each of these areas:

1. Primary Care.

The Region faces a shortage of over 375 primary care physicians, including shortages in the areas of Family, General Practice, and Internal Medicine.[13] The participating healthcare providers recognize the need to improve access to primary care clinics and after-hours physician services as an alternative to over-use of the already burdened emergency room

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[10] Hudspeth County Herald, Hudspeth Leads State in Rate of Uninsured, September 7, 2012, *available at* http://hudspethcountyherald.com/hudspeth-county-leads-state-in-rate-of-uninsured.

[11] The Annie E. Casey Foundation, Kids Count Data Center, El Paso County Profile, 2009 Data, *available at* http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=TX&loc=6585.

[12] Blue Ribbon Committee, Regional Strategic Health Framework, Needs Assessment Report (2011).

[13] US- Intellimed. November, 2010.

facilities. In the face of such a primary care shortage it is critical to ensure continued access for these patients to those providers while increasing access overall. The RHP finds that the Region must prioritize the recruitment of primary care physicians in these areas.

Primary care includes Family/General Practice/Internal Medicine, OB/GYN and Pediatrics as well as extended providers including mid-levels and nurses. The greatest shortages of primary care physicians are Family/General Practice/Internal Medicine, with a need for over 365 physicians in El Paso alone. (See graph below.)

Areas of Focus:

- Access to preventive/primary care for the indigent population.
- Two to three month wait time to have an appointment with an MD.
- General shortage of physicians due to mal-distribution and access.
- High levels of patient service suffer due to high patient loads resulting from poor reimbursement.
- Difficulty with patient compliance and returning for a follow-up.
- Physician recruiting strategies; it is difficult to replace physicians who leave.
- Growth of the Region's community of physicians who understand the culture with more emphasis placed on social and cultural aspects in medical school.
    - Language barrier makes attracting physicians to the area more difficult.
- Reciprocity agreement with other states; if a physician has a license in New Mexico, they cannot practice in Texas.
- Mexican physicians work in the US as Physician Assistants due to the difficulty in becoming fully licensed for US practice.
- Education and awareness on the risk of pregnancy in older women with chronic illnesses in the Region.
- No pediatric care in Hudspeth County; General Practice physicians will take children, but they are not set up for health check-ups.
- Availability of physician extenders (NP, PAs).
    - Lack of reimbursement for the training and hiring of new nurses.
- Shortage of Physical and Occupational Therapy faculty.
- Shortage of OT, respiratory therapist, x-ray tech, medical assistants, nurse aids.

Workgroup Recommendations:

- Provide mobile exam rooms in order to increase accessibility at a lower cost.
- Provide community workshop with all providers, rather than fragmented health fairs.
- Expand upon program with El Paso Community College and the Magnet schools to obtain high school diploma and LVN concurrently.
- Reestablish previously successful Texas Teach-Lubbock tele-consult programs in the county (ended due to shortage of funding).
- Utilize Nurse Practitioners and Physician Assistants as much as possible to relieve the strain on physician supply.

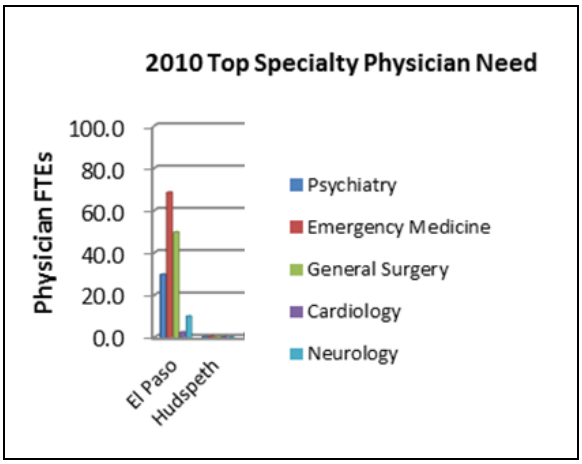
Additional Region 15 Areas to Improve:

- Increase recruitment and retention efforts for primary care physicians.
- Increase residency training programs for primary care, nurses, and physician assistants.
- Private entity partnership with Texas Tech, UMC and other teaching entities to create recruiting and training plan.
- Develop follow-up and discharge navigation systems to track patients for follow-up care.
- Train physicians and support staff on culturally competent care.
- Work to improve reciprocity regulations on a national and international basis.
- Increase attention to health promotion activities including wellness and healthy habits.
- Increase availability of women's preventative screening and primary care access.

Primary Care Summary: As displayed in the data and work group sessions, the need to recruit Family/General Practice/Internal Medicine, OB/GYN and Pediatricians as well as mid-levels, nurses and physician assistants needs to be a priority in the Region. Region 15 will continue to examine physician-recruiting strategies in order to retain medical students in the Region. The culture of Region 15 is unique and the language barrier can present challenges that create a deficiency in care from physicians not previously exposed to border medicine. The use of Mid-levels (Physician Assistants and Nurse Practitioners) in conjunction with physicians could greatly impact the need for primary care. As discussed in work group sessions, physician outreach programs on a rotational or part-time basis and the use of general healthcare mobile units in underserved areas would help with access in the communities.

2. Secondary and Specialty Care.

A related challenge faced in Region 15 is the need for more specialty physicians, and particularly specialty physicians in Psychiatry, Emergency Medicine, General Surgery, Cardiology, and Neurology (as shown in the specialty provider chart below).



Source: US- 1) Intellimed 2010 2) AMA 2010
Note: US physician supply removed physicians over age 65 to account for retirement.

In many cases, patients are forced to travel to Houston, Dallas, or outside the State of Texas to receive the specialty care that they need. Region 15 continues to face shortages of specialists willing and able to provide care to the low-income population. As noted with Primary Care, it is also crucial that specialists in Region 15 are able to practice and communicate with a very diverse patient population. Additional interpreters, support staff with language skills, and increased cultural training for healthcare providers will contribute to the effective delivery of healthcare services in the Region.

In the absence of adequate specialty care, low-income patients resort to hospital emergency rooms that can only provide part of the needed care and at significantly higher costs. This over-use of the emergency room is inconsistent with the intent of the Waiver, which focuses on providing high-quality care in an appropriate setting. By collaborating and identifying specialists and unique care delivery models including pharmacists, advanced practice nurses, physician's assistants and telemedicine, to assist in providing follow-up care, the participating providers can increase the availability of quality healthcare and reduce the reliance on hospital emergency rooms for such care.

Areas of Focus:

- Under-supply of physicians in El Paso, particularly specialists in the areas of Psychiatry, Emergency Medicine, General Surgery, Cardiology, and Neurology.
- Cancer services in outreach areas.
- Services for special needs children from 3-5 years of age and potential funding available for those without private insurance.

Additional Region 15 Areas to Improve:

- Recruitment and retention of specialist providers.
- Increased interpretation or language skills for specialists and support personnel
- Limited access to specialty care in rural or remote areas.

Secondary and Specialty Care Summary: As noted by the physician data, the greatest specialty care needs to address include Psychiatry, Emergency Medicine, General Surgery, Cardiology, and Neurology. Although there are needs across the Region in almost all specialty areas, it is also crucial that specialists recruited to the community are prepared for practice in a border environment and have the skills or support to communicate with a largely Hispanic and Latino population. Additionally, the provision of specialty services to low-income patients is essential to improving the overall health of Region 15 The work group sessions discussed the idea that physician outreach programs on a rotational or part-time basis, along with telemedicine and other remote technology advancements could be established in the rural areas to help with access to those communities in need.

3. Diabetes.

According to the American Diabetes Association, 18.8 million people in the United States have been diagnosed, along with another 7 million undiagnosed cases. Texas has one of the highest diabetes rates in the nation, with over 426,000 residents diagnosed with diabetes.[14] Like the rest of Texas, Region 15 has a high number of diabetes-related hospitalizations per year, and incidences of major cardiovascular disease, heart disease, stroke, ketoacidosis and lower extremity amputations, which have been closely tied to diabetes.[15] The El Paso Diabetes Association reports that in 2007 alone, local hospitals spent over $75 million treating diabetes-related emergencies.[16]

Diabetes is on of the most common chronic diseases in the El Paso area, and continues to be a target for health promotion and early intervention efforts in the community. Early disease detection improves the prognosis for most health problems and can contribute to increased survival rates, well-being, and a reduction in treatment costs.

A lower rate of preventative screenings for Diabetes indicators and other chronic disease markers reflect the overall limited access to health care in the Region as compared to the rest of the nation. In Region 15, there is a much higher percentage of the population that is not accessing regular preventative care screenings. For example:

- In El Paso, 35.5% of adults (18 years old and older) had not had their cholesterol checked in five or more years, as compared to the US average of 22.5%.
- The percentage 50 year olds in Texas who have not had a blood in stool test within the past two years or a sigmoidoscopy in their lifetime was 80.7%, while El Paso was almost 84%.
- In the US, the percentage of males who have not had a rectal exam or a PSA test is about 78%; in El Paso it is 83.7%.
- The percentage of women over 40 who have not had a mammogram within the last two years is over 30% in El Paso, whereas it is about 23% nationally.
- The percentage of women over 18 who have not had a Pap smear is about 17% nationwide, while El Paso remains above 21%.
- These indicators for preventative screening demonstrate Region 15's sub-standard performance in relation to the national average and state-wide figures. The chart below depicts Region 15's diabetic screening rate as compared to the state-wide average.

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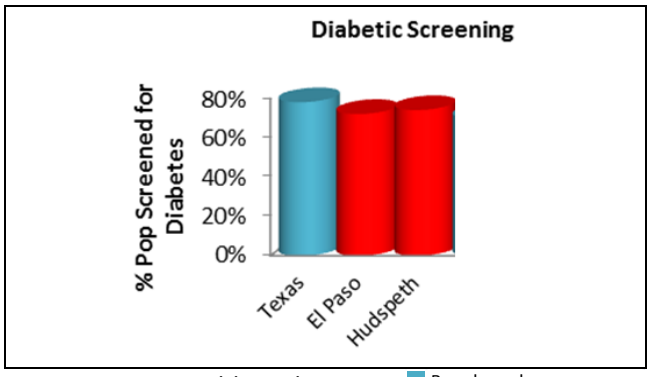
[14] Centers for Disease Control, Estimates of Diabetes Burden by State, available at: http://wonder.cdc.gov/wonder/sci_data/misc/type_txt/diab.asp.

[15] *Id*.

[16] Available at: http://www.epdiabetes.org/index.php/about-us



Source: County Health Rankings 2010, www.countyhealthrankings.org

Benchmark
Worse than Benchmark
Better than Benchmark

Areas of Focus:

- Prevention and awareness regarding the management of chronic care conditions (diabetes, mental health, etc.).
- Patient education on how to obtain follow-up care after a positive screening result with limited access options.
- Hudspeth County does not have disease screening at their clinics to address the following:
  - Hypertension
  - Diabetes
  - Prostate screening

4. Obesity.

In comparison to Texas and the nationwide average, the El Paso metropolitan area has a higher rate of people that are overweight and obese. About 64.8% of the population falls into one of these two categories, with 27.2% in the obese category (which represents a Body Mass Index of 30-99.8).[17] Obesity is also an increasing problem in the younger population of El Paso, as reported by the Paso Del Norte Health Foundation.[18]

Obesity ties to many Chronic Diseases, including Diabetes, Asthma, COPD, and CHF. If the Region's obese population continues to increase, health outcomes will decline and providers will be forced to manage much more serious chronic conditions. Currently, the Region has sporadic wellness education opportunities, such as local schools, churches, and healthcare provider-sponsored seminars or learning lunches. Wellness education and access to preventative care services will increase the knowledge base around healthy habits and begin to positively affect healthcare outcomes in this population.

[17] Study conducted by the Strategic Health Intelligence Planning Group, "Assessment of Determinants of Health in the PdNHF Region; available at: http://www.pdnhf.org/images/PDFs/border-reports/regional-health-assessment-2007.pdf.

[18] Original article in Borderzine, available at: http://borderzine.com/2011/06/childhood-obesity-in-el-paso-on-the-rise/.

Obesity has also been linked to Hispanic and other minority populations, which causes Region 15 to be more heavily affected than some other Texas regions. Healthcare Providers in the Region have determined that fighting obesity through community resources will lower the cost of the healthcare system overall, and improve outcomes for those patients in the long-term.

Areas of Focus:

- Access to healthy foods and healthy cooking technique.
- Network of pedestrian and bike paths and education to drivers regarding sharing the road with cyclists (lack of funding options for such initiatives).
- Programs that develop healthy life-long eating patterns.
- Access to and affordability of healthy food and promotion of such programs (i.e. food stamp purchases at farmer's markets).
- Access to child-friendly activities throughout communities.
- Wellness activities, parks, and after school programs
- Restoration of successful senior fitness programs.

Workgroup Recommendations:

- Establish programs to address education on healthy eating and provide greater access to healthy foods.
- Seek additional funding options to increase pedestrian trails, bike paths, and parks.
- Increase fitness and wellness activities in schools and senior centers.
- Extend programs that include education on healthy eating.
- Expand nutritional education resources throughout schools.

Obesity Summary: Being overweight or obese are associated with a number of chronic disease conditions.[19] Based on input from group sessions, despite several efforts in the region to improve nutritional knowledge, the population still lags in adoption of good habits. Workgroups noted that school nutrition programs need continued improvement. Additionally, better food habits require that healthy foods be available at affordable prices.

Physical fitness is important for overall physical well-being and mental health. Additionally, it is a good complement to weight reduction and maintenance programs. Workgroups noted that school-based physical activity programs need enhancement. Other suggestions included that future city development and public transportation plans could facilitate the incorporation of physical activity into daily living by developing pedestrian-friendly neighborhoods and communities with bike paths, sidewalks, and parks. Further groups recommended expansion of child-friendly physical activities throughout communities.

5. Behavioral Health.

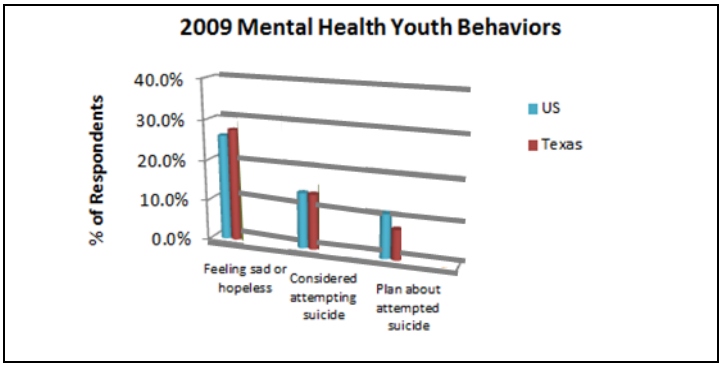
Of the residents in the Region who are in need of mental health services, less than half receive such services. Previous research indicates that Region 15 is operating beyond its capacity and is in need of an infusion of resources to address the lack of access to behavioral health services.

[19] *Strategic Health Intelligence Planning Group, Assessment of Determinants of Health in the PdNHF Region, 2009*

The Region recognizes that mental illness leads to high treatment cost and represents a health risk to the community, especially because many low-income patients utilize the emergency room as their primary access to behavioral healthcare. Additionally, mental illness is a major cause of disability, which drives up healthcare costs for the entire community. Lack of behavioral health management can lead to joblessness and inability to seek the limited resources available. Region 15 has determined that a variety of measures necessary, including: increasing the number of mental health providers, increasing mental health availability, and improving awareness of behavioral health.

Mental health patients are heavy users of medical and social services, but rarely have the resources to pay for those services. As a result of this disparity, much of the population needing behavioral health services utilize care in an inappropriate setting, such as the emergency room. A small number of persons with severe mental illness can endanger themselves or others, which can increase the costs of social services and criminal justice.

Regularly collected statistics for mental health are limited. Homicide and suicide rates in El Paso are currently below the state-wide average; however youth risk behavior surveys in Texas reveal high percentages of high school students with sad and suicidal thoughts and who had attempted suicide during the last 12 months before the survey. The results showed that these indicators are higher in Texas than the US average (see graph below – CDC YRBS, 2009).



Source: CDC: Youth Risk Behavior Survey.
NM data- New Mexico Department of health
http://apps.nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS

Areas of Focus:

- Lack of mental health providers in all service areas.
- Lack of mental health services (including depression management) resulting in patients having little access before a crisis.
- Lack of programs for patients once patients have been dismissed from an inpatient facility.
- There is an absence of geriatric psychiatric programs in the Region. This involves medically frail patients and non-payment for those with a dementia diagnosis.
- Population has difficulty affording of psychiatric prescriptions.

- The Counseling Center working with the juvenile courts only has counselors and licensed social workers. No psychologist or psychiatrist is on staff.
- Hudspeth County only provides psychiatric assessment at the county jail for community members who suffer from a psychotic episode.
- There is a problem with diversion of mental health patients in the Region.
- El Paso needs consistent protocols across programs (facilities, jails, etc.). Effective medications and medication management are not accessible as patients move through different programs in the system.
- Emergency Room holding for patients with mental health problems is too long (up to 172 hours).

Workgroup Recommendations:

- Improve education perception of behavioral health in communities across the Region.
- Create an awareness campaign regarding behavioral health and treating it as a chronic disease (similar to diabetes).
- Provide mobile services to outreach communities.
- Increase training for jail workers to deal with the behavioral health of inmates.
- Improve communication of behavioral health resources available to the Region through directories and other media.
- Improve formulary coordination and availability of consistent prescriptions across programs.

Additional Region 15 Areas to Improve:

- Establish a crisis-intervention center for low-income patients.
- Re-establish a psychiatric emergency department.
- Improve usage of telemedicine to reduce emergency room wait times for a psychiatric consultation.
- Increase behavioral health resources available to the elderly population.
- Increase education and resources to the youth of the Region and encourage early intervention and management of depression.

Behavioral Health Summary: According to Tomaka et al (2008),[20] about half (46%) of the residents in El Paso who are in need of mental health services receive them. The same report stated that the mental health system in El Paso is operating beyond its capacity and needs an infusion of $61.6 million ($28.5mm capital project and $33.5mm annual operating expenditures). It was discussed that better coordination among agencies dealing with patients may improve the use of existing scarce resources.

[20] *Tomaka L et al. Greater EL Paso Chamber of Commerce. Community Mental Health Survey. Institute for Health Policy and Economic Development. IPED Technical Reports 2008.*

6. Other Projects

The RHP recognizes and acknowledges that as the RHP is formed, Performing Providers will identify needs based on their unique target populations, missions and capabilities. The RHP agrees to work with each of these entities to identify and address possible areas of community needs under the Waiver.

Current Initiatives funded by DHHS

HHSC and CMS have asked that the RHP provide 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. Below are the initiatives submitted by Performing Providers in Region 15:

City of El Paso Department of Public Health

WIC-DSHS	Department of Agriculture, Food and Nutrition Service	3,475,538
Bio Terrorism Lab-DSHS	Department of Health and Human Services, Centers for Disease Control and Prevention	227,967
STD-HIV Federal-DSHS (STD Prev)	Department of Health and Human Services, Centers for Disease Control and Prevention	172,836
CHS-Fee for Service-DSHS	Department of Health and Human Services, Health Resources and Services Administration	291,280
HIV Surveillance - Federal-DSH	Department of Health and Human Services, Centers for Disease Control and Prevention	54,575
HIV Screening	Department of Health and Human Services, Centers for Disease Control and Prevention	414,415
TB Outreach	Department of Health and Human Services, Centers for Disease Control and Prevention	280,587
Bio Terrorism-Hazards	Department of Health and Human Services, Centers for Disease Control and Prevention	676,991
Nutrition Physical Activity and Obesity Prevention	Department of Health and Human Services, Centers for Disease Control and Prevention	50,000
Preparedness and Response, Hospital Preparedness Program	Department of Health and Human Services, Office of the Secretary	40,014
	Total	**5,684,203**

University Medical Center of El Paso

Poison Control Stabilization and Enhancement Program	U.S. Department of Health and Human Services / Health Resources and Services Administration	207,805
Family Planning Title X	U.S. Department of Health and Human Services / Texas Department of State Health Services	172,496
Family Planning Title XX	U.S. Department of Health and Human Services / Texas Department of State Health Services	294,174
Family Planning Title V	U.S. Department of Health and Human Services / Texas Department of State Health Services	9,899
	Total	**684,374**

Las Palmas Del Sol Medical Center

EHR Incentive Payments		9,147,457
	Total	**9,147,457**

Emergence Health Network, Texas Tech, and the Sierra Providence Health Network have confirmed that they do not currently have DHHS initiatives in their facilities.

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	*Primary Care*	• *US- Intellimed. Nov. 2010 - Note: US physician supply removed physicians over age 65 to account for retirement.*
CN.2	*Secondary and Specialty Care*	• *US- 1) Intellimed 2010 2) AMA 2010 - Note: US physician supply removed physicians over age 65 to account for retirement.*
CN.3	*Diabetes Management / Prevention / Care*	• *Centers for Disease Control, Estimates of Diabetes Burden by State, available at: http://wonder.cdc.gov/ wonder/sci_data/misc/type_txt/diab.asp.* • http://www.epdiabetes.org/index.php/about-us
CN.4	*Obesity Prevention / Health Promotion*	• Study conducted by the Strategic Health Intelligence Planning Group, "Assessment of Determinants of Health in the PdNHF Region; available at: http://www.pdnhf.org/images/PDFs/border-reports/regional-health-assessment-2007.pdf. • http://borderzine.com/2011/06/childhood-obesity-in-el-paso-on-the-rise/.
CN.5	*Behavioral Health*	• *CDC: Youth Risk Behavior Survey, 2010.* • *Source: Department of State Health Services* *http://www.dshs.state.tx.us/chs/default.shtm* • *Tomaka L et al. Greater EL Paso Chamber of Commerce. Community Mental Health Survey. Institute for Health Policy and Economic Development. IPED Technical Reports 2008.*
CN.6	*Other Community Need, as Identified by the Performing Provider*	• *TBD by Provider.*

PART FIVE: SECTION IV. STAKEHOLDER ENGAGEMENT

A. RHP PARTICIPANTS ENGAGEMENT

UMC El Paso, as the Anchor Lead Representative for RHP 15, has successfully collaborated with RHP 15 participants and stakeholders throughout all stages of Waiver implementation in the region. UMC began to forward informational e-mails from HHSC to all stakeholders in the region in early 2012; since April 2012, the RHP has held public meetings on a monthly basis. (For supporting evidence of these activities, see section E of the Stakeholder Engagement Addendum.) A comprehensive group of stakeholders in the RHP (approximately 150 e-mail recipients) have been included in ongoing communications since the beginning of the Medicaid 1115 Waiver Program, and many of these stakeholders have participated in the public meetings held by the RHP (as evidenced by the meeting agendas, meeting minutes, and sign-in sheets included in sections E (1, 2, 3) of the Stakeholder Engagement Addendum). Early in the Wavier implementation process, UMC created an accessible website to house all of the RHP's public information and began updating this website on an ongoing basis. As Waiver documents were developed and released by HHSC, they were also added to the public RHP website, and UMC has continually notified the RHP stakeholders of these updates. (For supporting evidence of these updates, see the communications log contained in section E (8) of the Stakeholder Engagement Addendum.)

As the Waiver implementation process continued, UMC identified potential Performing Providers for Region 15 and reached out to them to educate them on their potential roles in the Waiver program. UMC conducted this outreach to potential Performing Providers through e-mail communications, phone conferences, and public meetings; UMC also distributed Waiver information to these potential Performing Providers as it was developed and released by HHSC. (See section E of the Stakeholder Engagement Addendum.) UMC requested that any entity in Region 15 which expressed interest in being part of the RHP (either as a performing provider, interested party, or other stakeholder) submit a letter of participation to UMC as the RHP's Anchor. (These letters are included in section E (4) of the Stakeholder Engagement Addendum.) Outreach efforts by UMC's CEO and Anchor Lead Representative were not limited to potential Performing Providers, but were also conducted with respect to other health-providing entities that are not considered Performing Providers under the Waiver program, including potential IGT entities. (Letters of support from such entities are included in section E (5) of the Stakeholder Engagement Addendum.)

Approximately five focused meetings were held with the County of El Paso and its division directors in order to educate the County on its role as a potential IGT entity. The Local Mental Health Authority (LMHA) was also involved in these meetings, due to the strong connection between behavioral health and county health promotion activities. Approximately five meetings were also held with the El Paso Health Department. Several of these RHP 15 stakeholders (including UMC, the Health Sciences Center, LMHA, and the local Health Department) sent representatives to HHSC's August 2012 Waiver Summit.

UMC also conducted focused meetings with the El Paso Medical Society. UMC has offered to be the IGT entity for the DSRIP amount allocated to Private Physicians under the PFM Protocol. A project will be developed during 2013 with the assistance of the Anchor Lead Representative and members of the Medical Society. UMC conducted additional outreach efforts that were specifically connected to the development of DSRIP projects by Performing Providers within RHP 15. Projects were submitted by ten potential Performing Providers. In its role as RHP 15 Anchor, UMC reviewed each project and used a scoring system to grade the project's merit under the Waiver Program and its impact on UMC patients. UMC then met with each entity individually and conducted a focused review of that entity's proposed projects. UMC assessed each project to determine whether the project matched the requirements of the DSRIP menu, while also identifying others projects that could be beneficial if implemented outside of the Waiver program. Based on these meetings and assessments, UMC chose four entities as Performing Providers for RHP 15's DSRIP projects. UMC plans to subcontract with several of the other entities that submitted proposals in order to supplement the goals of the Waiver Program and assist RHP providers in delivering the right care in the right setting for inpatients and ED patients.

Learning Collaborative – RHP 15's Performing Providers, IGT entities, and Anchor have held regularly-scheduled monthly meetings throughout the development of the Waiver (see section E (1) of the Stakeholder Engagement Addendum). As stated by HHSC and CMS, meeting and discussing Waiver successes and challenges is a way to facilitate open communication and collaboration among a RHP's participants. Meetings, calls, and webinars represent powerful tools for sharing ideas and experiences while working together to solve regional healthcare delivery issues and community needs. UMC, as the RHP 15 Anchor, anticipates that it will continue to facilitate a monthly meeting, and UMC may also organize RHP stakeholders into workgroups that could meet more frequently to address commonly encountered DSRIP project areas. UMC will continue to update and maintain the RHP website, which will continue to include Waiver information provided by HHSC, regional projects sorted by Performing Provider, contact information for each participant, and minutes, notes, and slides from each meeting, for the benefit of those parties that were unable to attend each meeting in person.

RHP 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities statewide to share the RHP's experiences and challenges in implementing its DSRIP projects, but we also recognize the importance of continuing ongoing regional interactions in order to effectuate local change. Through the use of both state and regional Learning Collaboratives, the stakeholders of Region 15 are confident that these efforts will be successful in improving the local healthcare delivery system for El Paso low-income and indigent population.

B. PUBLIC ENGAGEMENT

The Region 15 RHP has employed several strategies to engage the public in the development of its RHP plans. First and foremost, every RHP meeting has been a public

meeting, announced well in advance and conducted in a central location with ample parking. Additionally, the agenda and supporting documents for each meeting are posted on UMC's website in advance of each meeting, and the minutes of each meeting are posted after the conclusion of each meeting (see sections E (1, 2) of the Stakeholder Engagement Addendum). An introductory letter from UMC's President and CEO, posted on that same website, encouraged the public's participation in the Waiver process and requested feedback on the RHP Plan. Once the initial Plan was developed, public posting occurred on 10/29/2012. A letter from the Anchor CEO was sent to the entire Region 15 email listing with a link to the Region 15 website. Region 15 providers, participants, and interested parties were encouraged to contact the Anchor CEO or the Anchor Lead Representative with any comments or requests. We did add an executive summary document of all Region 15 DSRIP projects in a separate document and post on the website. This request was from a public official and to assist in reviewing the project concepts in a concise fashion. The letter is still posted on the website and the entire Region 15 Plan including the addendum are housed there.

Because UMC is a public entity, all of UMC's board and committee meetings are open meetings subject to the provisions of the Open Meetings Act. Additionally, all of UMC's board meetings are televised for convenient viewing by the general public. Implementation of the Waiver has been a standing item on UMC's monthly Finance Committee agenda throughout 2012 and continuing into 2013, and it has also been included in the UMC CEO's report to the Board at each monthly board meeting throughout 2012 and into 2013. In summary, all official discussions about Waiver implementation and RHP Plan development have been conducted publicly, and all meeting minutes and supporting documentation have been posted on the Anchor's website.

UMC's CEO also makes a quarterly report to the El Paso County Commissioner's Court. The Commissioner's Court meetings are likewise public meetings, duly announced in advance and streamed live on the County's website. These meetings are publicly also televised via tape-delay. Waiver implementation and RHP Plan development have been discussed in each of the UMC CEO's quarterly report to the Court since early 2012. The Commissioner's Court also received briefings regarding Waiver implementation and RHP Plan development throughout its 2012 budget preparation and approval process.

UMC's CEO also routinely accepts speaking engagements extended by community groups. In each of the community meetings the CEO has attended in 2012 and continuing into 2013, he has briefed attendees about Waiver implementation and RHP Plan development. The CEO also issues a weekly electronic publication called "The Friday Letter," which keeps readers abreast of issues affecting UMC. This publication is delivered to thousands of community stakeholders. Waiver implementation and RHP Plan development have constituted a recurring section of "The Friday Letter" throughout 2012 and continuing into 2013. (Relevant issues of this publication are included in section E (6) of the Stakeholder Engagement Addendum.)

PART SIX: SECTION V. DSRIP PROJECTS

A. RHP PLAN DEVELOPMENT

As a Tier III RHP, Region 15 has been required to select a minimum of 8 projects from Categories 1 and 2 combined, and to select at least 4 of those 8 projects from Category 2. RHP 15 is submitting a total of 53 Category 1 and 2 projects. Of the 53 total projects, 34 are in Category 1, and 19 are in Category 2.

To begin the process of developing DSRIP projects for the RHP Plan, the RHP Anchor (UMC El Paso) prepared a summary document of Pass 1 and Pass 2 Funding Performing Provider DSRIP allocation amounts, based on HHSC's protocol, illustrating how much each Performing Provider is entitled to claim during each Demonstration Year for the successful performance of DSRIP projects. Each Performing Provider then selected and developed its own projects, in accordance with the requirements of the PFM Protocol and the RHP Planning Protocol.

Within the RHP, focused meetings were held with Performing Providers to discuss possible overlap in market with similar projects, but the autonomy of each entity in their choice of projects was preserved. UMC led brainstorming sessions during the RHP's public meetings, which resulted in the identification of many potential projects that are included in the DSRIP menu, as well as several projects that could benefit the El Paso community despite not being included in the DSRIP menu. Early in this process, UMC provided a list of approximately 50 projects (see addendum D. DSRIP Projects Considered) to potential Performing Providers in the RHP, in order to spark further brainstorming and project development.

As HHSC added and removed DSRIP menu project options, RHP participants and stakeholders discussed which potential projects were permitted or not permitted under the DSRIP menu. UMC contributed uniquely to these discussions by participating in anchor conference calls with HHSC and sharing the HHSC's guidance with the other RHP 15 participants. For example, the RHP participants discussed the possibility of developing and implementing DSRIP projects to serve incarcerated patients in cooperation with the local mental health authority and heads of county departments. Based on HHSC's advice, the RHP participants and stakeholders determined that it was not appropriate to include these projects in the RHP Plan, due to HHSC's recommendation that patients served by a DSRIP project be eligible for Medicaid benefits.

As the Waiver rules developed and changed over time, UMC apprised RHP stakeholders of the latest changes via e-mail, slide presentations, and handouts at monthly stakeholder meetings. The RHP website has been regularly updated to include all relevant documents from the Anchor, HHSC, and CMS. Each Performing Provider was tasked with evaluating and selecting its own projects, and UMC acted as a gatekeeper to ensure all requirements contained in the Program Funding and Mechanics Protocol were met with respect to each project. UMC provided suggestions and project development assistance to Performing Providers, based on UMC's understanding of the requirements of the PFM Protocol. As the RHP prepared for the final submission of projects, UMC offered constant assistance and support to Performing Providers, as necessary.

The complete list of projects considered by Region 15 is included in the Addendum of this Plan.

RHP 15 has taken several steps to identify the needs of the region and to ensure that the DSRIP projects contained in the RHP Plan will address those needs. During the RHP's initial public meetings, RHP stakeholders and participants were involved in the development and adoption of the RHP's community needs assessment. Over the past three years, a Blue Ribbon Committee has operated under El Paso's Regional Strategic Health Framework, conducting extensive research on the health care needs of the community. Throughout the Waiver implementation process, Performing Providers have referred to the committee's findings and the community needs assessment in order to develop projects that are in alignment with the region's needs.

The region's goals focus on maintaining the high-quality care that our Performing Providers have historically provided, while managing the overly-frequent use of the ED as a first healthcare resource. Uninsured and indigent patients, including El Paso's substantial immigrant population, commonly use the ED as their primary access point to the healthcare system. Region 15 has a severe shortage of Primary and Specialty providers, so it is imperative that our region devote resources to expanding the presence of primary care and specialist providers in the community and the scope of services that they offer. Region 15, like many other regions throughout the state, faces a shortage of behavioral health resources. Behavioral health facilities currently operate above capacity, and Performing Providers in the region continue to struggle to provide adequate behavioral healthcare to their patients.

RHP 15 plans to achieve the goals set forth in the RHP Plan though the following steps:

- Increase access to primary care through the expansion of medical homes, primary care clinics, and more effective care navigation upon discharge;
- Provide the full continuum of healthcare services, including all aspects of healthcare, such as wellness, preventative care, emergent care, disease management, palliative and hospice care;
- Better manage patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, Epilepsy, Dementia, and Renal disease to help prevent unnecessary readmission and get patients the care they need to prevent, self-manage, and address their chronic diseases in an appropriate setting;
- Provide patient education to ensure the population is accessing the right care in the right setting;
- Overcome language, socio-economic, and monetary barriers to accessing healthcare resources in the region;
- Increase the number of specialists and scope of specialist services offered in the community;
- Address the issues of Diabetes and Obesity, which represent major health concerns in Region 15; and
- Increase patient satisfaction through delivery of high-quality, effective healthcare services.

Region 15 has not identified any performing providers who would be exempt from Category 4 reporting under Paragraph 11.E of the Program Funding and Mechanics Protocol.

B. PROJECT VALUATION

In order to improve access, availability, efficiency, delivery, and funding of healthcare in the Region, and to address the plight of the Region's Medicaid and indigent populations, the Region's Performing Providers have developed DSRIP projects that specifically address the needs of the Region, while also addressing the internal needs and areas for improvement identified by each Performing Provider. In order to value these projects, the Performing Providers in Region 15 designed a set of principles to consider in assigning project values. The principles for Region 15 that impact individual project values are:

- The project's ability to meet community needs;
- The acuity of the patient population served;
- The size of the population served;
- Cost savings to the healthcare delivery system;
- Benefit to the overall Regional delivery framework;
- Cost of implementation (project planning; hiring and training physicians, mid-level staff, and administrative staff; availability and appropriateness of existing space; equipment upgrades; etc.);
- The project's likelihood to transform and improve care delivery in the community; and
- The degree to which each project meets Waiver goals, such as the "triple aim."

In keeping with the transparency and openness RHP 15 has demonstrated throughout the implementation of the Waiver, RHP 15 offered each Performing Provider an opportunity to customize its own specific valuation methodology within the framework of the RHP's general valuation principles. Due to the unique roles of the various providers in the RHP, each Performing Provider applied the Region 15 principles slightly differently in assigning project values.

Region 15 Hospitals – UMC, Las Palmas, Providence, Sierra, and Sierra East: Hospital providers in Region 15 selected four areas of focus from the Regional principles and used those four areas as a framework for their project valuations. The four areas of emphasis for RHP 15 Hospitals are: (1) addressing Waiver goals (e.g., CMS's "triple aim"); (2) addressing community needs; (3) acuity and size of population served; and (4) project investment. Each individual project was assigned a weight of between 1 and 5 for each of these four factors, and the sum of these weights was used to determine the valuation of the project. The sum of weights for each project served as an objective measure to ensure that each project's valuation correlated to that project's advancement of regional priorities.

Once each of the Hospitals had valued its projects, the RHP participants discussed each Hospital's methodology and specific valuation results to ensure consistency between providers.

These project values do vary based on provider-specific issues (as discussed in detail below); however, the Anchor and other RHP Hospitals are in agreement that these project valuations are consistent with guidance from HHSC and CMS, as well as being consistent with the goals of the Waiver.

Texas Tech University Health Sciences Center – El Paso – Paul L. Foster School of Medicine: Texas Tech considered a series of factors in establishing a valuation for each of its projects. Texas Tech considered the level of human resources required to meet the milestones of the project, and whether that level could be met through new hires or through the assignment of existing support personnel. Texas Tech also considered what non-personnel resources would be required for the successful implementation of each project, and the necessity of properly-timed resource deployment; such resources may include custom equipment for a certain specialty, or additional space for new or expanded initiatives. In considering each project's resource needs, Texas Tech considered the amount of potential revenue each project could generate, offsetting these revenues against resource demands.

Furthermore, Texas Tech conducted a risk assessment for each project. This assessment examined the complexity of the project, the scope of the project, the extent to which any single-point failure in a milestone would jeopardize downstream success, the degree of the project's dependence on other projects within the Waiver program and institutional initiatives outside the Waiver, and the amount of time required to manage the project. Texas Tech also considered the magnitude of community benefits that might result from the successful implementation of each project. Finally, Texas Tech considered its own organizational priorities and the extent to which Texas Tech was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

Emergence Health Network: Emergence assigned values to each of its projects based on the average cost and length of stay for inpatients, ED patients, and incarcerated patients.

Differences in Project Valuations: In addition to the disparity in Performing Providers' methodologies for assigning project values, there are many provider-specific variables that have affected each Performing Provider's valuation of its DSRIP projects. In some situations, these variables may have caused two superficially similar projects to be assigned different values. These provider-specific variables include provider size, current capabilities, population served, milestones and metrics chosen, internal resources, current personnel strengths, and project size. In accordance with guidance from HHSC, UMC allowed Performing Providers wide latitude in selecting valuation methodologies and assigning values to their projects. Given HHSC's guidance on appropriate valuation techniques, UMC is confident that each Performing Provider in Region 15 has complied with the intent of the Waiver with respect to project valuation.

Project Option 1.9.1 Expand Specialty Care Capacity: **EXPANDED RESIDENCY PROGRAM**

Unique Project ID: 138951211.1.1

Performing Provider Name/TPI: University Medical Center of El Paso (UMC)
TPI: 138951211

Project Summary:

University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

Intervention(s): This project will create new Fellowship and Residency slots that will train at UMC and treat our patients (via Texas Tech Residency and Fellowship Programs). We plan to add at least 18 new resident and fellowship slots based on approved ACGME applications. Additional Resident slots for Orthopedics (3) and Radiology (3) will begin in DY3 (1 each), DY4 (1 each), and DY5 (1 each). Three new specialties will begin in DY 2 to include Cardiology (2), GI (2), and Nephrology (2). However, the Resident/Fellow terms do not begin until July each year, so the patient impact will not be recorded until DY3 = approximately 6400; DY4 = 11,500; FY5 = 16,600.

Need for the project: El Paso suffers from a shortage of primary and specialty physicians. Overall, there are approximately 116 physicians per 100,000 people in El Paso, well below the state average of 162 MDs per 100,000.

Target population: UMC patients, 65% either Medicaid or Unfunded.

Category 1 or 2 expected patient benefits: The expected outcome of additional physicians in training at UMC will provide timely care to our patients in need. Each Resident or Fellow will treat approximately 200 patients per year at UMC based on the FTE formula taken from the hospital's most recent cost report data. Radiology cases will average 5,000 per Resident and total 30,000 additional by the term of the Waiver. Total Patient impact will be approximately 34,000 patients treated and cases read.

Category 3 outcomes: OD-14 Workforce Outcomes IT -14.6, IT-14.7, IT-14.8 Residency Training Program. Our extended goal for the region is to ultimately retain much needed primary and specialty physicians in El Paso. Our goal is to add 18 additional Residency and Fellowship

slots by DY5. Via the outcome domain established for workforce enhancement projects, we will survey the physicians in training regarding their intentions of serving healthcare shortage areas in their upcoming careers. Through all the additional service line enhancements UMC is implementing, we plan to provide an attractive environment for the retention of physicians once they graduate from Residency and Fellowship Programs on the campus.

Project Description:

This project will establish an ongoing rotation in El Paso for residents based at Texas Tech University Health Sciences Center (Texas Tech) in El Paso.

Under this project, UMC El Paso will assist Texas Tech in expanding the residency programs for several specialties, including Cardiology, Gastroenterology, Orthopedics, Nephrology, and Radiology. This project will also assist Texas Tech in establishing residency programs in Maternal Fetal Medicine and Pelvic Floor Residencies / Fellowships. This project will require commitment of local specialists to specific teaching and administrative responsibilities, supported by faculty and resident stipends and other supportive resources provided by the hospital.

The project will involve the continuing assessment of El Paso's needs for additional specialty providers and increased specialty services capacity in the identified specialties and other specialties. The project will increase the number of specialists in the El Paso community, and improve the specialty provider workforce, by improving specialty provider recruitment efforts; UMC will accomplish this primarily by offering additional residencies in El Paso, which will increase the likelihood of successfully recruiting new graduates to practice in the community. UMC will also conduct quality improvement activities as part of the expanded residency programs.

Goals and Relationship to Regional Goals:

Project Goals: The immediate goal of this project is to increase the annual number of program participants over the years of the Waiver. Another goal of this project is to provide positive exposure to opportunities in El Paso for these residents, thereby increasing the likelihood of successfully recruiting these new graduates to practice in this area.

This project meets the following regional goals: This project meets the regional goal of increasing the number of specialists and scope of services offered in the community. This project will increase specialty services by expanding residency programs for specialty areas of identified need, thus bringing more specialty providers to the region.

Challenges:

A limited number of local specialists are available to provide teaching support. Significant funding is required to support this new program. Federal funding (Medicare Direct Graduate Medical Education or DGME) for residency training is capped at 1996 levels for the direct support of graduate medical education. The cap only supports a third of the costs of 4,056 of the

4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13%. The benefit of additional Residency / Fellowship programs will allow our hospital to provide timely and more efficient care to our patients; however, challenges occur with our partner teaching entity providing the adequate resources, instructors and facilities etc in order to obtain approval from ACGME. This project has good support for the positions/slots we will add. ACGME, Faculty, physical environment are all approved for the residencies and fellowships offered through this program. Other challenges include retention of physicians in the El Paso area after program is completed. El Paso has not offered an attractive environment for relocation of physician and family in the past. We hope the addition of specialty services and newly created fellowship programs will improve the retention of physicians in the El Paso area.

5-Year Expected Outcome for Provider and Patients:

UMC expects this project to increase the capacity of 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. This will enable much-needed diagnostic testing and services for the unfunded and underfunded population.

Starting Point/Baseline:

At the inception of the Waiver, UMC had 181 residents participating in its programs in Anesthesia, Emergency Medicine, Family Medicine, Orthopedics, Radiology, and Psychiatry. New programs will begin in GI, Cardiology, and Nephrology. The baseline for this project will begin December 2011 to measure approved ACGME applications and additional enrollees into the program.

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. This project is imperative because El Paso needs more local specialists so that patients will not have to travel long distances, endure long wait times, or receive lower quality care due to the shortage of specialists in the area. Residency programs require 3 to 8 years of training, depending on the specialty. Medicare funding only covers years 1 through 3. In 2011, Texas had more than 550 residency programs, offering a total of 6,788 positions. Only 22% (1,494) of these were first-year residency positions. According to the Coordinating Board, conservative estimates indicate that the cost to educate a resident physician for one year is $150,000. There is a great need for extended residency programs in Texas and, in general, an increase in the number of specialists.

Project Components: 1.9.1 Expand high impact specialty care capacity in most impacted medical specialties

The expansion of specialty residency programs at UMC El Paso will accomplish the following core project components (a-d):

a) Identify high impact/most impacted specialty services and gaps in care and coordination.

   - UMC has already identified significant gaps with respect to residency programs in Cardiology, Gastroenterology, Orthopedics, Nephrology, Family Medicine, and Radiology.
   - UMC will continue to assess the need for these and other specialty services in the El Paso community.

b) Increase the number of residents/trainees choosing targeted shortage specialties

   - UMC will increase the number of residents and trainees in the targeted specialties by expanding the residency programs for these specialties.

c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)

   - UMC intends that these expanded residency programs will provide residents with positive exposure to opportunities in El Paso, increasing the likelihood that the residents can be successfully recruited to (and retained in) the El Paso community.

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.

   - UMC will conduct quality improvement activities as part of the expanded residency programs.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care

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

This project will significantly enhance UMC's efforts to train new specialty providers and recruit and retain them in the El Paso community. UMC currently offers residencies in some of the

specialties with identified needs, but some of the specialties (i.e., GI, Cardiology, and Nephrology) do not have any dedicated residency programs at UMC. Because these new and/or expanded residency programs will increase the likelihood that new graduates will choose to practice their specialties in El Paso, this project will significantly enhance UMC's ability to train, recruit, and retain new specialty providers to serve patients in the region.

Related Category 3 Outcome Measures:

OD-14 Workforce Projects
TSC Resident and Fellow Program
IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA), or medically underserved area (MUA) (138951211.3.1)
IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey (138951211.3.18)
IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey (138951211.3.19)

Reasons/rationale for selecting the outcome measures:

One of the major challenges in Region 15 is recruiting and retaining quality physicians. As a result of this expanded Residency program, UMC expects that a greater number of graduates will remain in Region 15, and more specifically, the El Paso Area. While it is understandable that many physicians choose to practice in areas with a higher percentage of insured, paying patients, UMC expects that after serving a residency in a high-quality facility making a difference to those that need it most – the uninsured and Medicaid population.

Relationship to other Projects: This project will complement UMC's Establish Nurse Residency and Simulation Lab project (138951211.1.6); both projects will focus on improving access to specialty care in the El Paso community by training new physician and mid-level providers in an acute-care residency setting.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary or specialty care in the community. TTUHSC is developing a project to enhance the residency programs available in El Paso.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing

to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the costs and health complications that can be avoided when a patient population receives the right care in the right setting, rather than being forced to utilize the Emergency Department as its primary healthcare resource. This project will significantly address the needs of the El Paso community by increasing 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.

138951211.1.1	***1.9.1***	1.9.1a-d	***EXPANDED RESIDENCY PROGRAM***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-14 Workforce Projects	IT-14.6 IT-14.7 IT-14.8	138951211.3.1 138951211.3.18 138951211.3.19	**OD-11 Addressing Health Disparities in Minority Populations** IT-11.6 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-14]: Expand targeted specialty care (TSC) training. Metric 1 [P-14.1]: Expand the TSC residency, mid-level provider (physician assistants and nurse practitioners), and/or other specialized clinician/staff training programs and/or rotations. Data Source: Documentation of applications and agreements to expand training programs Milestone 1 Estimated Incentive Payment: $1,612,276 **Milestone 2** [CQI P-19]: 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 1 **[**P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: 2/month Data Source: Documentation of weekly or bi-weekly phone meetings,	**Milestone 3** [P-16]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents. Metric 1 [P-16.1]: ACGME approval for residency position expansion. Baseline/Goal: Obtain ACGME approval for 18 new TSC residency positions. Data Source: Documentation of ACGME approval for residency position expansion. Baseline/Goal: Approximately 6400 patients Milestone 3 Estimated Incentive Payment: $1,758,906 **Milestone 4** [CQI P-19]: 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 1 [P-19.1]: Number of bi-	**Milestone 5** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Goal: Approximately 11,500 patients / cases Data Source: Student/trainee rotation schedule. Milestone 5 Estimated Incentive Payment: $3,528,038	**Milestone 6** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Goal: Approximately 16,600 patients / cases Data Source: Student/trainee rotation schedule. Milestone 6 Estimated Incentive Payment: $2,914,466

138951211.1.1	***1.9.1***	1.9.1a-d	***EXPANDED RESIDENCY PROGRAM***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-14 Workforce Projects	IT-14.6 IT-14.7 IT-14.8	138951211.3.1 138951211.3.18 138951211.3.19	**OD-11 Addressing Health Disparities in Minority Populations** IT-11.6 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)**
conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes Milestone 2 Estimated Incentive Payment: $1,612,275	weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: 2/month 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 Milestone 4 Estimated Incentive Payment: $1,758,906		
Year 2 Estimated Milestone Bundle Amount: $3,224,551	Year 3 Estimated Milestone Bundle Amount: $3,517,812	Year 4 Estimated Milestone Bundle Amount: $3,528,038	Year 5 Estimated Milestone Bundle Amount: $2,914,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,184,867			

92434

Project Option 1.10.2 Enhance performance improvement and reporting capacity through technology: **ELECTRONIC MEDICAL RECORDS**

Unique Project ID: 138951211.1.2
Performing Provider Name/TPI: Medical Center of El Paso (UMC) / TPI: 138951211
Project Summary:
University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs. It is estimated the patient impact will be 10,000 in DY3, 10,500 in DY4, 11,000 in DY5 with the implementation of the project (EMR and participation in national collaboratives).

Interventions: This is a new program for UMC. Under this project, UMC will participate in nationally validated, risk-adjusted, outcomes-based programs to measure and improve the quality of trauma and surgical care (TQIP and NSQIP). UMC will implement robust electronic medical record (EMR) and data collection systems to provide the infrastructure for improving patient care and decreasing the incidence of Potentially Preventable Complications and Healthcare Acquired Conditions.

Need for the project: UMC does not currently participate in a nationally validated, risk-adjusted, outcomes-based program. Hospitals participating in the NSQIP program averaged 250-500 averted events. UMC's 2011 data reveals the top six most common events totaled 479 complications. This project will not receive other sources of federal funding.

Target population: The target population is our surgical and trauma patients which are at a higher risk for contracting a complication. However, the implementation of a robust EMR along with participation in an outcomes-based program will benefit all of our patients. Approximately 60% of our patients are either Medicaid eligible or indigent, so we expect they will highly benefit from these projects. Expected impact from this program is approximately 10,000 UMC discharges in DY3, 10,500 in DY4 and 11,000 in DY5.

Category 1 or 2 expected patient benefits: The project seeks to: participate in a national collaborative to drive targeted quality improvements; hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools, and processes to measure improvement and trends; in DY4 increase the number of reports generated over DY1 by generating reports from 3 systems; in DY5 increase the number of reports generated over DY1 by generating reports from 5 systems.

Category 3 outcomes: IT-4.3 Our goal is to reduce the ***Catheter-Associated Urinary Tract Infection (CAUTI) Rates*** from 7.9/1000 (2011) patient days (ICU med/surgical) currently to 5.65/1000 patient days (ICU med/surgical) by DY5.

Project Description:

Under this project, UMC will implement robust electronic medical record (EMR) and data collection systems to provide the infrastructure for improving patient care.

Participating in a collaborative has been shown to drive targeted and concerted quality improvement activities with the support of peers and the program. Gaining access to national databases for trauma and surgical cases will save time before, during, and after the provision of treatment, increase patient satisfaction, and allow practitioners to provide more holistic diagnoses and treatment. In addition, the implementation of robust electronic medical record (EMR) and data collecting systems will provide the infrastructure to improve patient care by increasing compliance with evidence-based standards of care and decrease untoward events. This project will incorporate the following databases to improve quality and efficiency in the applicable departments: provider was

1. **TQIP:** Participation and implementation of the Trauma Quality Improvement Project (TQIP) trauma records database.
2. **SQIP:** Participation and implementation of NSQIP surgical records database.
3. **Lighthouse:** Participation and implementation of Cerner's Lighthouse components including Stroke, Emergency Department (ED) Throughput, and Venous Thromboembolism (VTE). Engaging Cerner in the second year and proceeding to full implementation, to include all Core Measures, IQHealth (Cerner patient portal) and e-prescriptions, by DY5.
4. **WHC EMR:** Participation and implementation of an electronic documentation system for the University Medical Center of El Paso Women's Health Center (WHC).
5. **OB Airstrip:** Interfacing Obstetrics (OB) Airstrip with current fetal heart tone surveillance program, Navicare, and providing access to the OB Airstrip application to OB providers who labor and deliver patients at UMC.
6. **MedMined:** It provides a Healthcare Associated Infection Marker with objective, real-time and consistent quality measurement and hospital-wide scope.
7. **Surginet:** Surginet is Cerner's Perioperative Service Software application.
8. **Maternal Infant:** Navicare, Cerner (UMC's EMR) interface; This program is critical to assuring consistent sharing of patient information throughout the facility.

Goals and Relationship to Regional Goals:

Project Goals: The goals of this project include allowing inter-disciplinary access to a patient's records for better quality care. This project will also improve the quality of care and improve patient outcomes for trauma and surgical patients and decrease adverse and "never" events by participating in nationally validated, risk-adjusted, outcomes-based programs to measure and improve the quality of trauma and surgical care (TQIP and NSQIP). In combination with using an evidence-based, data-driven, technology-leveraged approach (i.e., Lighthouse, WHC EMR,

OB Airstrip, , Surginet), these additional resources for tracking and measuring will increase the quality of care available at UMC.

This project meets the following regional goals: This project meets the regional goal of increasing patient satisfaction through delivery of high-quality, effective healthcare services. This project will meet this goal by improving UMC's ability to engage in quality improvement and reporting activities, in order to provide a higher quality of healthcare services at UMC.

Challenges:

Implementing these initiatives will require application, implementation, training, personnel, and utilization in order to be successful. Further challenges include training providers on each of the new resource databases and ensuring that support staff that work with these key areas are aware of, have access to, and can effectively use these resources. These challenges will be addressed through extensive provider education and training by various means: service line specific educational sessions, committees, memo's and one to one encounters. Education to support staff will also be provided on each of the new resource databases in order to provide the needed support to the providers. Education will be tracked to ensure the appropriate providers have been provided the training/education. Action plans will be formulated in the event the practitioner requires additional training/support or is reluctant to utilize additional resources.

5-Year Expected Outcome for Provider and Patients:

UMC expects that its neighborhood health centers (NHCs) will expand their quality improvement capacity through the development and increase of people, processes, and technology, so that the resources are in place to conduct, report, drive, and measure quality improvement, ensuring better health outcomes for the patients served by the NHCs.

Starting Point/Baseline:

Currently, UMC not participate in any specialty databases (excluding the Trauma Registry).

1. TQIP: UMC does not participate in this database.
2. SQIP: UMC does not participate in this database.
3. Lighthouse: UMC does not have this EMR capability.
4. WHC EMR: UMC does not have this EMR capability.
5. OB Airstrip: UMC does not have this EMR capability.
6. MedMined: UMC does not have this EMR capability.
7. Surginet: UMC does not have this EMR capability.
8. Maternal Infant: UMC does not have an integrated, one-source) medical record for mother and baby.

Rationale:

UMC believes that the acquisition and implementation of these programs will achieve the aims of the Waiver by decreasing adverse and "never" events and improving patient outcomes, as compared to the benchmark, through the following activities:

- Participation in national collaboratives (NSQIP and TQIP);

- Hiring and training of personnel in quality improvement statistical process control tools and methods;
- Acquiring and implementing electronic (computer) programs to assist in data collection, display, and reporting; and
- Creating a comprehensive quality dashboard.

1. **TQIP:** The trauma population is unique and complex which poses a performance/process improvement challenge. Although, data is collected and submitted to the National Trauma Data Bank, aggregate reports are provided months after submission. This poses a challenge when the organization relies on timely data to correct and improve practice and processes. Participation in TQIP will assist the organization to measure the trauma center's performance using process and outcomes measures to better understand our strengths and areas for improvement
2. **NSQIP:** Hospitals participating in the NSQIP program averaged 250-500 averted events, as reported in the Annals of Surgery (Annals of Surgery 205 (3): 363-376. 2009. The prevention of these types of events means improved patient care, reduced hospital stays and avoidance of cost incurred to treat these conditions. NSQIP provides the structure whereby 120 variables per patient: Pre, intra and post-operative are monitored. This close monitoring is performed in real time as opposed to retrospective monitoring, which is not ideal in the prevention of adverse events.
3. **Cerner:** Each year, more than 650,000 patients (nationwide) experience a preventable event leading to needless pain, injury, and even death. These events not only affect the patient, but are very costly to the organization and payers. Additionally, the lack of sophisticated technology requires manual abstraction of Core Measure elements and other data from the paper and electronic chart. Critical patient and process information are captured retrospectively, too late for preventative measures. The implementation of an electronic system which has the capability to alert the provider of potential omission or inclusion of critical patient care elements will drastically reduce the potential for adverse events. A system capable of providing alerts will also provide the infrastructure to improve patient care by increasing compliance with evidence-based standards of care, such as Core Measures. With the full implementation of Lighthouse (Cerner), patients will be able to access health information through a secure electronic portal. This will provide the patient vital information such discharge summary, medication regimen, which the patient can provide to his/her primary care physician. Electronic e-prescription will reduce the potential for medication errors, thus avoiding potential harm to patient and possible readmission.
4. **WHC EMR:** None of the WHC sites have EMR for the family planning service. The staff transports paper medical records to each clinic site on a daily basis. The benefits of acquiring an EMR would be: 1. The elimination of the need to transport charts to/from each of the current six locations, 2. The space used to store the records would be utilized to provide healthcare services.
5. **OB Airstrip:** Expectations to intervene to prevent harm or poor outcomes are mandated but require accurate real-time interpretations of the fetal heart tone tracing. Access to the OB Airstrip application increases patient safety as the primary OB physician familiar

with the patient and guiding the care of patient has immediate access to view and interpret the fetal surveillance tracing at any time from any location; this enables timely interventions to promote optimal outcomes.

6. **MedMined Services:** The program is set up to electronically determine which cultures are true healthcare acquired infections and also allows the units to access their infection rates and provides them with recommended actions based on best practice for reducing those infections.
7. **Surginet**: Implementation of Surginet is essential in order to have compatibility of software systems. It would facilitate the acquisition of data for meaningful use and to have one source of truth for surgical patients. This infrastructure will improve patient care by increasing compliance with evidence-based standards of care and decrease the potential for untoward events.
8. **Maternal Infant:** The transfer to Cerner as both the fetal surveillance and the overall documentation program for L&D will facilitate creation of a comprehensive electronic medical record thus improving communication of pertinent patient information and increasing patient safety.

Project Components:

This project will accomplish the following project components:

a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
   - UMC will train the relevant staff on the use of the new EMR systems, electronic databases, and quality improvement infrastructure as part of the implementation of the systems, databases, and infrastructure.

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.
   - UMC will develop and implement an employee suggestion system with respect to those employees who utilize the new systems, databases, and infrastructure.

c) Conduct quality improvement for the project using methods such as rapid cycle improvement. 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.
   - UMC will use its new systems, databases, and infrastructure, after implementation, to conduct quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-6: Other Projects

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

This project will significantly enhance the care provided to El Paso residents by UMC by improving the quality of that care. Currently, UMC is limited in its ability to undertake meaningful quality improvement activities due to a lack of appropriate technology infrastructure.

Related Category 3 Outcome Measures:

OD-4: Potentially Preventable Complications and Healthcare Acquired Conditions
IT-4.3: Catheter-Associated Urinary Tract Infections (CAUTI) rates

Reasons/rationale for selecting the outcome measures:

Through the implementation of the electronic systems described above, real-time information will be captured which will alert process participants of increased potential for a Catheter-Associated Urinary Tract Infection (CAUTI) to develop. For example, leading indicators will alert the Quality Management department when a particular patient possesses all the high risk indicators which contribute to the development of a CAUTI (e.g., dehydration, immobility, elderly, Foley catheterization, etc.). Preventative measures can then be implemented to avoid the actualization of a CAUTI.

Relationship to other Projects: This project is one of several UMC projects which aim to improve the quality and availability of primary care services in the El Paso community, including Establishing the Crossroads Clinic in Southwestern El Paso (138951211.1.3); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4). UMC will also be establishing a similar expansion of quality improvement capabilities for its neighborhood health centers (NHCs) (138951211.1.7).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: This project is an internal improvement to be implemented at UMC and does not directly relate to other performing providers' projects in the region. However, the implementation of better reporting will make it easier for UMC to document lessons learned and best practices which it develops within its facility, for sharing with other regional performing providers, which may lead to better support for DSRIP projects and better patient outcomes throughout the region.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to

effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which enhanced reporting capacity through increased access to electronic medical records databases will address community needs, the population served, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). The necessity for improved electronic medical records systems is ever present. Organized and documented performance improvement processes and effective reporting of the results are critical to make and sustain appropriate changes. Skilled staff and effective technology are vital to ensure that our health care system is providing optimum patient health outcomes. The value of the project also includes startup and maintenance costs such as licenses, hardware and software, education, travel, subscription fees, implementation fees, and other such requirements.

138951211.1.2	***1.10.2***	(1.10.2 a-b)	***ENHANCE IMPROVEMENT CAPACITY WITHIN SYSTEMS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s):	***IT-4.3***	138951211.3.2	***Catheter-Associated Urinary Tract Infection (CAUTI) Rates***

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]: Participate in statewide, regional, public hospital, or national learning collaborative to drive targeted quality improvements. This should include collaboratives using clinical database(s) for standardized data sharing. Metric 1 [P-3.1]: Documentation of collaborative membership. Baseline: Zero membership in national collaboratives. Goal: Membership in one national collaborative. Data Source: Collaborative membership materials. Milestone 1 Estimated Incentive Payment: $1,018,279 **Milestone 2** [CQI P-7]: 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 1 [P-7.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Goal- Participation in two meetings, conference calls, or	**Milestone 3** [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools, and processes, such as rapid-cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends). Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles. Baseline: Trained staff in PI principles is 7% of the total Quality Management Staff. Goal: Increase baseline of 7% of trained staff to goal of 13% over DY1. Numerator: Number of staff trained. Denominator: Total number of staff. Data Source: HR; training programs. Annual patient impact 10,000 in DY3. Milestone 3 Estimated Incentive Payment: $1,110,888 **Milestone 4** [CQI P-7]: Participate in at least bi-weekly interactions (meetings, conference calls, or	**Milestone 5** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities. Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline: Reports generated from 1 principal system. Goal: Increase the number of reports generated over DY1 by generating reports from 3 systems. Data Source: Quality improvement data systems. Annual patient impact 10,500 in DY4. Milestone 5 Estimated Incentive Payment: $2,228,235	**Milestone 6** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities. Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline/Goal: Increase the number of reports generated over DY1 by generating reports from 5 systems. Data Source: Quality improvement data systems. Annual patient impact 11,000 in DY5. Milestone 6 Estimated Incentive Payment: $1,840,716

138951211.1.2	***1.10.2***	(1.10.2 a-b)	***ENHANCE IMPROVEMENT CAPACITY WITHIN SYSTEMS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s):	***IT-4.3***	138951211.3.2	***Catheter-Associated Urinary Tract Infection (CAUTI) Rates***	
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)**
webinars organized by the RHP per month. 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. Milestone 2 Estimated Incentive Payment: $1,018,279	webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Goal- Participation in two meetings, conference calls, or webinars organized by the RHP per month. 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. Milestone 4 Estimated Incentive Payment: $1,110,888			
Year 2 Estimated Milestone Bundle Amount: $2,036,558	Year 3 Estimated Milestone Bundle Amount: $2,221,776		Year 4 Estimated Milestone Bundle Amount: $2,228,235	Year 5 Estimated Milestone Bundle Amount: $1,840,716
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,327,284				

94487

Project Option 1.1.1 Expand Primary Care Capacity by establishing additional Primary Care Clinics: **ESTABLISH MORE PRIMARY CARE CLINICS UMC NHC - CROSSROADS**

Unique Project ID: 138951211.1.3
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a/ University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso.

Intervention: New Project -This project will expand access to primary and urgent care in the RHP Region, by opening a new Primary Care Clinic at Crossroads and Mesa with expanded evening and weekend hours serving the Westside of the City of El Paso.

Need for Project: Region 15 has identified expansion of Primary care as its first priority in its community needs. The area of El Paso identified for the Crossroads clinic is in the North-West near the I-10/Mesa interchange, which is not being served by a primary care clinic at this time. This area is underserved, and Crossroads will provide a point of access to the healthcare system to the populations that need it most – the uninsured and indigent population

Target Population: Underserved people living in zip codes 79912, 79922, 79932 who have not had a place in their area to go for care.

Category 1 or 2 expected patient benefits: evidence of improved access for patients seeking services Documentation of increased number of visits. We expect to have 1200 patient visits in Y2, 3000 patient visits in Y3, 4500 patient visits in Y4 and 6000 patient visits in Y5 Goal: 14,700 Total Visits

Category 3 Outcomes: OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Rate 1: Patient is getting timely care, appointments, and information.

Project Description:

This project will expand access to primary and urgent care in the RHP Region, by opening a new Primary Care Clinic at Crossroads and Mesa with expanded evening and weekend hours serving the Westside of the City of El Paso.

Target Zip Codes: 79912, 79922, 79932

Goals and Relationship to Regional Goals:

Project Goals: Expand, increase, and improve access to primary and urgent care services within the RHP Region.

This project meets the following regional goals: This project meets the regional goal of providing increased access to the healthcare delivery system. Primary care in a clinic setting is utilized by uninsured and indigent populations. This project will assist in getting those patients the much-needed primary care support that is in short-supply throughout the region.

Challenges:

Many patient populations are wary of high costs, long wait-times and long drive times for primary care, and decide not to seek non-emergency treatment and/or preventative care. The success of this project will rely on educating these populations as to the health and financial benefits of primary/preventative care, and notifying the public of the expanded, local after hour urgent care availability. The implementation of this program will present staffing and space challenges, as well as the challenges involved in supervision of a much expanded outpatient system.

5-Year Expected Outcome for Provider and Patients:

We expect that we will reach a new population and that existing patients from this area will see a reduction in appointment wait-time for out-patient primary visits and a reduction in wait for urgent care. Additionally, there will be a reduction of wait times for ED patients due to appropriate utilization of urgent care sites. UMC expects to effectuate cost avoidance by seeing patients in the right place, right setting, rather than continuing to let the ED be a source of primary care. We also expect to see an improvement in Patient Satisfaction.

Starting Point/Baseline:

Currently, there are three UMC- Neighborhood Health Centers in operation in El Paso. However, the rapid increase in patient populations requiring access to affordable primary care has created significant delays in appointment times, which leads to a reduction in persons opting to seek care for non-emergent conditions and an increase in otherwise manageable conditions leading to hospital admissions. Many areas of the region have limited after hours/urgent care availability increasing inappropriate utilization of the hospital EDs. This baseline will be the beginning of the operation of the clinic and the hours and days of operation. The volume of patient visits during the operating hours will be measured. Patient satisfaction will also be measured from a starting point of zero.

Rationale:

Region 15 has identified expansion of Primary care as its first priority in its community needs, designating it as CN.1, as shown below. Increasing access to care has far-reaching effects within the community including getting patients access to care in the right place, right setting, reducing

inappropriate ED admission, and cost avoidance of inpatient treatment for care that is better served in an ambulatory setting.

Project Components:

The establishing a new primary care clinic will use the following project components:

a) P-1 Establish primary care clinic.

b) P-4 Expand the hours of a primary care clinic, including evening and/or weekend,

c) P-5 Hire and Train additional primary care providers and staff

d) I-12 increase primary care clinic volume and evidence of improved access for patients seeking services,

e) CQI Milestone: P-8 Participate in at least biweekly interactions with other HP to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1

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

Currently, UMC operates 3 fully-functional neighborhood health clinics, which are located in the Eastern and Southwestern areas of the City of El Paso and in Fabens in the Southwestern area of El Paso County. The area of El Paso identified for the Crossroads clinic is in the North-West near the I-10/Mesa interchange, which is not being served by a primary care clinic at this time. This area is underserved, and Crossroads will provide a point of access to the healthcare system to the populations that need it most – the uninsured and indigent population

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Rate 1: Patient is getting timely care, appointments, and information.

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the increased access to primary care through the lens of the patient. Patient satisfaction with timeliness and access to information will help determine whether there is adequate access to care in the community.

Relationship to other Projects: UMC has several other projects dedicated to expanding primary care, including 138951211.1.4: Establishing the UMC NHC East; 138951211.1.5: Expand existing primary capacity: UMC NHC Ysleta and Fabens

Patient Centered Medical Home Expansion, Expand Chronic Care Management Models, Enhance Performance Improvement and Reporting Capacity]

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of primary care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which increased access to primary care through opening a new primary care clinic in the NW area of El Paso with expanded hours of service. This will address the community needs, the population served, resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Increased access to primary care will help address a substantial need in the community for increased access to primary care while reducing wait times for appointments and increasing patient satisfaction. This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes. Additionally, seeing patients in an ambulatory setting promotes the appropriate level of care in the appropriate setting and reduces unnecessary ED admissions for conditions better served in a clinic setting.

138951211.1.3	***1.1.1***	138951211.1.3	***ESTABLISH PRIMARY CARE CLINIC - CROSSROADS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD - 6	***IT-6.1***	138951211.3.3	***Patient Satisfaction***

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 providers and staff Metric **P-5.1** Documentation of increased number of providers and staff Data Source Materials showing additional staff, HR documents, schedules, training dates and agendas, sign in sheets Baseline: 0 Visits Goal: 1200 visits DY2/14,700 visits by DY5 Milestone 1 Estimated Incentive Payment *(maximum amount)*: $1,074,851 **Milestone 2** **P-1** Establish more primary care clinics Metric **P-1.1** Documentation of additional clinic at Crossroads Data Source Plans, Schedules, Signage	**Milestone 4** P-4 Expand the hours of a primary care clinic including evening and/or weekend. Metric P-4 Documentation of increased number of hours above Year 1 Data Source Signage, EMR, Schedules Goal: 3000 visits Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,758,906 **Milestone 5** **CQI**: P-8 Participate in at least biweekly interactions with other providers and RHP to promote collaborative learning around shared or similar projects **P-8.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in	**Milestone 6** **I-12** increase primary care clinic volume and evidence of improved access for patients seeking services Metric **I-**12.1 Documentation of increased number of visits. Initial baseline measurement is zero. Total number of visits for reporting period. Data Source EMR, Schedules Goal: 4500 Visits Milestone 6 Estimated Incentive Payment: $3,528,038	**Milestone 7** **I-12** increase primary care clinic volume and evidence of improved access for patients seeking services Metric **I-**12.1 Documentation of increased number of visits. Total number of visits for reporting period. Data Source EMR, Schedules Goal: 6000 Visits DY5/ Total visits 14,700 Milestone 7 Estimated Incentive Payment: $2,914,466

138951211.1.3	***1.1.1***	138951211.1.3	***ESTABLISH PRIMARY CARE CLINIC - CROSSROADS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD - 6	***IT-6.1***	138951211.3.3	***Patient Satisfaction***

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: Open a new primary care clinic at Crossroads and Mesa Milestone 2 Estimated Incentive Payment *(maximum amount)*: $1,074,850 **Milestone 3** **CQI**: P-8 Participate in at least biweekly interactions with other providers and RHP to promote collaborative learning around shared or similar projects **CQI: P-8.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in Data Source Schedules, agendas, emails, sign-in sheets, presentations… Goal: Hold two meetings per month Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,074,850	Data Source Schedules, agendas, emails, sign-in sheets, presentations… Goal: Hold two meetings per month Milestone 5 Estimated Incentive Payment: $1,758,906		
Year 2 Estimated Milestone Bundle Amount: $3,224,551	Year 3 Estimated Milestone Bundle Amount: $3,517,812	Year 4 Estimated Milestone Bundle Amount: $3,528,038	Year 5 Estimated Milestone Bundle Amount: $2,914,466

138951211.1.3	***1.1.1***	138951211.1.3	***ESTABLISH PRIMARY CARE CLINIC - CROSSROADS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD - 6	***IT-6.1***	138951211.3.3	***Patient Satisfaction***	
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 *(add milestone bundle amounts over Years 2-5)**:*** $13,184,867				

93648

Project Option 1.1.2 Expand Existing Primary Care Capacity: **UMC NEIGHBORHOOD HEALTH CENTER EAST**

Unique Project ID: 138951211.1.4
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a/ University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso.

Interventions: Expansion of current services - This project will expand access to primary and urgent care in the RHP Region, and more specifically the East area of El Paso County by relocating and expanding the Montwood Clinic to a much larger site offering many additional services including additional primary care staff, evening and Saturday hours, Women's Health Services including ultrasound, a regional laboratory and a pharmacy.

Need for the project: We expect that patients will see a reduction in appointment wait-time for out-patient primary care visits in this area due to expanded capacity. The UMC Montwood Clinic is currently suffering from a shortage of space, staff, and resources. This project will relocate the clinic to a larger space and expand service availability. This area is underserved, which is evidenced by the overwhelming number of patients that cannot be seen because the clinic is at-capacity. This expansion will allow increased access to the healthcare system to the populations that need it most – the uninsured and indigent population.

Target population: Underserved people living in zip codes 79935, 79936, 79925, and 79928.
We expect to have 5245 patient visits in Y2, 9000 patient visits in Y3, 12,000 patient visits in Y4 and 14,000 patient visits in Y5 for a total of 40,241 visits which also include lab, pharmacy and ultrasound services. If the baseline rate had continued we would have been able to provide only 18,792 primary care visits during this same time period

Category 1 or 2 expected benefits – increase primary care clinic volume and evidence of improved access for patients seeking services Documentation of increased number of visits by 10% over DY3 Increase to 5,182 visits

Category 3 outcomes: OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Rate 1: Patient is getting timely care, appointments, and information.

Project Description:

This project will expand access to primary and urgent care in the RHP Region, and more specifically the East area of El Paso County by relocating and expanding the Montwood Clinic to a much larger site offering many additional services including additional primary care staff, evening and Saturday hours, Women's Health Services including ultrasound, a regional laboratory and a pharmacy.

Target Zip Codes: 79935, 79936, 79925, and 79928.

Goals and Relationship to Regional Goals:

Project Goals: Expand, increase, and improve access to primary and urgent care services within the RHP Region.

This project meets the following regional goals: This project meets the regional goal of increasing access to primary care through the expansion of medical homes, primary care clinics, and more effective care navigation upon discharge. This project will assist in getting those patients the much-needed primary care support that is in short-supply throughout the region.

Challenges:

Many patient populations are wary of high costs, long wait-times and long drive times for primary care, and decide not to seek non-emergency treatment and/or preventative care. The success of this project will rely on educating these populations as to the health and financial benefits of primary/preventative care, and notifying the public of the expanded, local after hour urgent care availability. The implementation of this program will present staffing and space challenges, as well as the challenges involved in supervision of a much expanded outpatient system.

5-Year Expected Outcome for Provider and Patients:

We expect that patients will see a reduction in appointment wait-time for out-patient primary visits and a reduction in wait for urgent care. Additionally, there will be a reduction of wait times for ED patients due to appropriate utilization of urgent care sites. UMC expects to effectuate cost avoidance by seeing patients in the right place, right setting, rather than continuing to let the ED be a source of primary care. We also expect to see an improvement in patient satisfaction.

Starting Point/Baseline:

Currently, there are three NHCs in operation in El Paso. However, the rapid increase in patient populations requiring access to affordable primary care has created significant delays in appointment times, which leads to a reduction in persons opting to seek care for non-emergent conditions and an increase in otherwise manageable conditions leading to hospital admissions. Many areas of the region have limited after hours/urgent care availability increasing inappropriate utilization of the hospital EDs. Our baseline before the relocation and expansion is 4,698 visits, with no evening or weekend hours.

Rationale:

Region 15 has identified expansion of Primary care as its first priority in its community needs, designating it as CN.1, as shown below. Increasing access to care has far-reaching effects within the community including getting patients access to care in the right place, right setting, reducing inappropriate ED admission, and cost avoidance of inpatient treatment for care that is better served in an ambulatory setting.

Project Components:

The establishing a new primary care clinic will accomplish the following core project components (a-c):

a) Expand Primary care clinic space
   - P-1 Establish primary care clinic. By relocating to a new location, the clinic will gain additional space, and thus, additional capacity to provide primary care

b) Expand primary care clinic hours
   - P-4 Expand the hours of a primary care clinic, including evening and/or weekend

c) Expand primary care clinic staffing
   - P-5 Hire and Train additional primary care providers and staff
   - I-12 increase primary care clinic volume and evidence of improved access for patients seeking services,

d) CQI Milestone: P-8 Participate in at least biweekly interactions with other HP to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1

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

Currently, UMC operates 3 fully-functional neighborhood health clinics, which are located in the Eastern and South-Western areas of the City of El Paso and in Fabens in the Southwestern area of El Paso County. The UMC Montwood Clinic is currently suffering from a shortage of space, staff, and resources. This project will relocate the clinic to a larger space and expand service availability. This area is underserved, which is evidenced by the overwhelming number of patients that cannot be seen because the clinic is at-capacity. This expansion will allow increased

access to the healthcare system to the populations that need it most – the uninsured and indigent population.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Rate 1: Patient is getting timely care, appointments, and information.

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the increased access to primary care through the lens of the patient. Patient satisfaction with timeliness and access to information will help determine whether there is adequate access to care in the community.

Relationship to other Projects: UMC has several other projects dedicated to expanding primary care, including 138951211.1.3: Establishing the Crossroads Clinic in South-western El Paso, 138951211.1.7: Enhancing Quality Improvement in the UMC NHCs, 138951211.1.5: Expanding Primary Care at Ysleta and Fabens, and 138951211.2.4: Expansion and Enhancement of Medical Homes at UMC NHCs.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of primary care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing

DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which increased access to primary care through relocating the Montwood Clinic to a much larger location on George Dieter as well as expanding the hours of service and increasing the availability of lab, pharmacy and Women's Health will address the community needs, the population served, resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Increased access to primary care will help address a substantial need in the community for increased access to primary care while reducing wait times for appointments and increasing patient satisfaction. This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes. Additionally, seeing patients in an ambulatory setting promotes the appropriate level of care in the appropriate setting and reduces unnecessary ED admissions for conditions better served in a clinic setting.

138951211.1.4	***1.1.2***	1.1.2.a-c	***EXPAND PRIMARY CARE CAPACITY – NHC EAST***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD – 6	***IT-6.1***	138951211.3.4	***Patient Satisfaction***

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 providers and staff **Metric P-5.1** Documentation of increased number of providers and staff **Data Source** Documentation Milestone 1 Estimated Incentive Payment *(maximum amount)*: $1,612,276 **Milestone 2** **P-1** Establish more primary care clinics **Metric P-1.1** Documentation of relocation of clinic to larger site at East **Data Source** New primary care schedule Baseline: 4,698 visits Goal: 5241 DY2/ 40241 visits by DY5 including primary and ancillary services Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,612,275	**Milestone 3** **P-4** Expand hours of the NHC East clinic, including evening and weekend hours **Metric P-4.1 Increase number of hours at NHC East clinic over baseline** **Data Source** EMR, Ancillary service reports Goal: Provide 9000 visits Milestone 3 Estimated Incentive Payment: $3,517,812	**Milestone 4** **I-12** increase primary care clinic volume and evidence of improved access for patients seeking services **Metric I-12.1** Documentation of increased number of visits by 10% over DY2 **Data Source** EMR Goal: Provide 12,000 visits Milestone 4 Estimated Incentive Payment: $3,528,038	**Milestone 5** **I-12** increase primary care clinic volume and evidence of improved access for patients seeking services **Metric I-12.1** Documentation of increased number of visits by 10% over DY3 **Data Source** EMR Goal: Provide 14,000 visits for a total of 40,241 visits including primary and ancillary services Milestone 5 Estimated Incentive Payment: $2,914,466

138951211.1.4	***1.1.2***	1.1.2.a-c	***EXPAND PRIMARY CARE CAPACITY – NHC EAST***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD – 6	***IT-6.1***	138951211.3.4	***Patient Satisfaction***	
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: $3,224,551	Year 3 Estimated Milestone Bundle Amount: $3,517,812		Year 4 Estimated Milestone Bundle Amount: $3,528,038	Year 5 Estimated Milestone Bundle Amount: $2,914,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: $13,184,867				

93631

Project Option 1.1.2 Expand Existing Primary Care Capacity: **UMC NEIGHBORHOOD HEALTH CENTERS YSLETA AND FABENS**

Unique Project ID: 138951211.1.5
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a/ University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso. Our Fabens location has a rural health center designation.

Intervention: Expansion of current services- This project will expand access to primary and urgent care in the RHP Region, and more specifically El Paso County. UMC will expand primary and urgent care staffing, services and hours at two existing Neighborhood Health Centers at Ysleta and Fabens helping them to become minor hub sites which provide lab in addition to primary care**.**

Need for the project: There are currently no evening or weekend hours at either the Ysleta or Fabens Neighborhood Healthcare Centers. Many providers are extremely busy with third next available appointments out over a month.

Target population: Underserved people living in the Ysleta Area: 79907 and 79927, and the Fabens Area: 79849, 79838 and 79928

Category 1 or 2 expected benefits: I-12 increase primary care clinic volume and evidence of improved access for patients seeking services. Documentation of increased number of visits over baseline of 31,329. We expect to have 34,860 patient visits in Y2, 37,500 patient visits in Y3, 40,500 patient visits in Y4 and 43,500 patient visits in Y5 for a total of 156,360 visits. If the baseline rate had continued we would have been able to provide only 125,316 primary care visits during this same time period

Category 3 outcomes: OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Rate 1: Patient is getting timely care, appointments, and information.

Project Description:

This project will expand access to primary and urgent care in the RHP Region, and more specifically El Paso County. UMC will expand primary and urgent care staffing, services and hours at two existing Neighborhood Health Centers at Ysleta and Fabens helping them to become minor hub sites which provide lab in addition to primary care.

Target Zip Codes: Ysleta Area: 79907 and 79927, Fabens Area: 79849, 79838 and 79928

Goals and Relationship to Regional Goals:

Project Goals: Expand, increase, and improve access to primary and urgent care services within the RHP Region.

This project meets the following regional goals: This project meets the regional goal of providing increased access to the healthcare delivery system. Primary care in a clinic setting is utilized by uninsured and indigent populations. This project will assist in getting those patients the much needed primary care support that is in short-supply throughout the region.

Challenges:

Many patient populations are wary of high costs, long wait-times and long drive times for primary care, and decide not to seek non-emergency treatment and/or preventative care. The success of this project will rely on educating these populations as to the health and financial benefits of primary/preventative care, and notifying the public of the expanded, local after hour urgent care availability. The implementation of this program will present staffing and space challenges, as well as the challenges involved in supervision of a much expanded outpatient system.

5-Year Expected Outcome for Provider and Patients:

We expect that patients will see a reduction in hospital admissions and the deterioration of manageable conditions. We also expect a reduction in appointment wait-time for out-patient primary care visits and a reduction in wait for urgent care. Additionally, there will be a reduction of wait times for ED patients due to appropriate utilization of urgent care sites. UMC expects to effectuate cost avoidance by seeing patients in the right place, right setting, rather than continuing to let the ED be a source of primary care. We expect to an improvement in patient satisfaction due to convenient hours, additional providers, and ease of access to care.

Starting Point/Baseline:

Currently, there are three NHCs in operation in El Paso. However, the rapid increase in patient populations requiring access to affordable primary care has created significant delays in appointment times, which leads to a reduction in persons opting to seek care for non-emergent conditions and an increase in otherwise manageable conditions leading to hospital admissions. Many areas of the region have limited after hours/urgent care availability increasing inappropriate utilization of the hospital EDs.

Baseline at the Fabens NHC for FY11, no evening or weekend hours 10,698 total patient visits.

Baseline at the Ysleta NHC for FY11, no evening or weekend hours 20,631 total patient visits.

Rationale:

Region 15 has identified expansion of Primary care as its first priority in its community needs, designating it as CN.1, as shown below. Increasing access to care has far-reaching effects within the community including getting patients access to care in the right place, right setting, reducing inappropriate ED admission, and cost avoidance of inpatient treatment for care that is better served in an ambulatory setting.

Project Components: 1.1.2 Expand Existing Primary Care Capacity

a) Expand primary care clinic hours
   - P-4 Expand the hours of a primary care clinic, including evening and/or weekend

b) Expand primary care clinic staffing
   - P-5 Hire and Train additional primary care providers and staff
   - I-12 increase primary care clinic volume and evidence of improved access for patients seeking services,

c) CQI Milestone: P-8 Participate in at least biweekly interactions with other HP to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1

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

Currently, UMC operates 3 fully-functional neighborhood health clinics, which are located in the Eastern and Southwestern areas of the City of El Paso and in Fabens in the Southwestern area of El Paso County. In order to accommodate the ever-growing population, it has become necessary to expand services provision at the Yselta and Fabens clinics. This project will add additional providers and expand hours, to provide services to patients that are only able to receive care on the weekends and evenings. This area is underserved, which is evidenced by the overwhelming number of patients that cannot be seen because the clinic is at-capacity. This expansion will allow increased access to the healthcare system to the populations that need it most – the uninsured and indigent population

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores

- Rate 1: Patient is getting timely care, appointments, and information.

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the increased access to primary care through the lens of the patient. Patient satisfaction with timeliness and access to information will help determine whether there is adequate access to care in the community.

Relationship to other Projects: UMC has several other projects dedicated to expanding primary care, including 138951211.1.3: Establishing the Crossroads Clinic in West El Paso; 138951211.1.4: Expanding Primary Care Capacity at NHC East; 138951211.2.4: Patient Centered Medical Home Expansion; 138951211.2.5:Expand Chronic Care Management Models; 138951211.1.7: Enhance Performance Improvement and Reporting Capacity.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of primary care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which increased access to primary care through expanding the hours of service and increasing the availability of urgent care at its Ysleta and Fabens clinics will address the community needs, the population served, resources and cost necessary to implement the project, and the project's ability to meet the goals

of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Increased access to primary care will help address a substantial need in the community for increased access to primary care while reducing wait times for appointments and increasing patient satisfaction. This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes. Additionally, seeing patients in an ambulatory setting promotes the appropriate level of care in the appropriate setting and reduces unnecessary ED admissions for conditions better served in a clinic setting.

138951211.1.5	***1.1.2***	138951211.1.5.b-c	***EXPAND EXISTING PRIMARY CARE CAPACITY – NHCS YSELTA AND FABENS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD – 6 Patient Satisfaction	***IT-6.1 Percent Improvement Over Baseline for Patient Satisfaction Scores***	138951211.3.5	***Patient Satisfaction*** ***Patient is Getting Timely Care, Appointments, and Information***

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 providers and staff Metric **P-5.1** Documentation of increased number of providers and staff Data Source Clinic Schedules by Provider, HR documentation, contracts Baseline: Fabens/Ysleta: 31,329 visits Goal: 32,860 visits DY2 and 43,500 visits in DY5 Milestone 1 Estimated Incentive Payment: $1,357,706 **Milestone 2** **CQI**: P-8 Participate in at least biweekly interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in	**Milestone 3** **P-4** Expand the hours of a primary care clinic, including evening and/or weekend Metric **P-4.1** Increased number of hours at primary care clinic over baseline Data Source Clinic Documentation Goal: 37,500 visits Milestone 3 Estimated Incentive Payment: $1,481,184 **Milestone 4** **CQI**: P-8 Participate in at least biweekly interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **P-8.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in	**Milestone 5** **I-12** increase primary care clinic volume and evidence of improved access for patients seeking services Metric **I-**12.1 Documentation of increased number of visits. Initial baseline measurement is zero for after hours and weekend hours. Total number of visits for reporting period. Data Source EMR, Schedules Goal: 40,500 visits Milestone 5 Estimated Incentive Payment: $2,970,979	**Milestone 6** **I-12** increase primary care clinic volume and evidence of improved access for patients seeking services Metric **I-**12.1 Documentation of increased number of visits. Total number of visits for reporting period. Data Source EMR, Schedules Goal: 43,500 visits DY5 Total visits for DY2-DY5 156,360 Milestone 6 Estimated Incentive Payment: $2,454,288

138951211.1.5	***1.1.2***	138951211.1.5.b-c	***EXPAND EXISTING PRIMARY CARE CAPACITY – NHCS YSELTA AND FABENS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD – 6 Patient Satisfaction	***IT-6.1 Percent Improvement Over Baseline for Patient Satisfaction Scores***	138951211.3.5	***Patient Satisfaction*** ***Patient is Getting Timely Care, Appointments, and Information***	
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 Meeting Agendas, sign-n sheets, conference calls, presentations, email Goal: 2 meetings per month Milestone 2 Estimated Incentive Payment *(maximum amount)*: $1,357,705	Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Goal: 2 meetings per month Milestone 4 Estimated Incentive Payment: $1,481,184			
Year 2 Estimated Milestone Bundle Amount: $2,715,411	Year 3 Estimated Milestone Bundle Amount: $2,962,368		Year 4 Estimated Milestone Bundle Amount: $2,970,979	Year 5 Estimated Milestone Bundle Amount: $2,454,287
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $11,103,046				

93638

Project Option 1.9.3 Expand Specialty Care Capacity: **ESTABLISH NURSE RESIDENCY AND SIMULATION LAB**

Unique Project ID: 138951211.1.6
Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211
Project Summary: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs. El Paso suffers from a shortage of primary and specialty care services. Overall, there are approximately 116 physicians per 100,000 people in El Paso, well below the state average of 162 MDs per 100,000. This directly corresponds to associated nursing staff with focused training in specialty care.

Intervention(s): This is a new program for UMC and we will establish a Preceptor and Nurse Residency program accompanied with an on-site simulation lab environment to assist in education, training, and critical thinking skills of the new associates employed in specialized units. The nurses will have a learning environment to become experts in specialized care in line with UMC's streamlined specialty care currently in process, and with the additional physician residents we plan to enroll. UMC expects that the establishment of these nurse training programs will also raise the retention rate for Graduate Nurses. .

Need for the project: UMC is in the process of streamlining our specialty services to more effectively and efficiently treat our patients and their specialized conditions. For example, our orthopaedic unit will also contain rehab staff and equipment; a specific Geriatric unit to focus on their particular needs; new Endoscopy Suite and specialized diagnostic equipment; Neurosurgical Center of Excellence. The Graduate Nurses entering the Residency Program will be separated into their specialized training programs of interest and are mentored by a qualified preceptor. The specialty areas include, but not limited to: Trauma, Critical Care, Neuro Intensive Care, Cardiovascular Intensive Care, Interventional Radiology (Cardiac and Neurological), Emergency, Surgical, Orthopediacs, Geriatrics, Medical, Oncology, Women's Surgical/Ortho, Labor & Delivery, Maternal Infant, Gastrointestinal to include Endoscopy, and Perioperative Services. The use of simulation training is a highly recognized tool for development of assessment skills and critical thinking needed to care for various types of patients across the continuum of care. Along with increased physician residents in specialties, our nurses need to be experts in specialized care to assist the physicians and troubleshoot patient issues sooner rather than later.

Target population: UMC patients, 65% either Medicaid or Unfunded. With the new and streamlined services, we will be able to treat this population currently lacking proper access to diagnostic care and treatment.

Category 1 or 2 expected patient benefits: The patient expected outcome of this program will provide for expert quality care in patient's specialty needs and enable our nurses to complement our physician specialist services, as well as troubleshoot patient's needs timely and effectively. Our goal is to train approximately 30 nursing students by DY5; however, this may increase due to it being a new program. Turnover and attrition rates may also have an effect on our workforce training. This project will benefit approximately 4620 patients in DY3 and 7700 patients in DY4 and 8260 in DY5.

Category 3 outcomes: OD-14 Workforce Projects IT -14.6, IT-14.7, IT-14.8 TSC Nurse Graduate Residency Program. UMC expects that the establishment of these nurse training programs will raise the retention rate for graduate nurses within the first two years of hire by 3%. UMC also expects that this project will improve TCS nursing services within these programs. Via the outcome domain established for workforce enhancement projects, we will survey the nurses in training regarding their intentions of serving healthcare shortage areas in their upcoming careers. The 15 new Nurse Residents will be surveyed at the time of entry into the Nurse Residency program for DY3. A total of 18 Nurse Residents for DY4 (20% increase) and 20 new Nurse Residents for DY5 (10% increase over DY4) will be surveyed.

Project Description:

Under this project, UMC El Paso will develop, implement, and evaluate a comprehensive nurse residency program at UMC El Paso for graduate nurses.

UMC will develop and initiate an evidence-based nurse residency program at UMC. This program will include an in depth preceptor program, in order to ensure a holistic approach. UMC will develop, and/ or collaborate with an existing Simulation Lab that will provide an environment where graduate nurses can reinforce didactic content, learn and practice skills, and develop critical thinking, decision-making, and organizational skills, while providing holistic patient care.

In order to support these programs, UMC will recruit and hire nurse educators in their field of expertise. UMC will also develop unit-specific specialty educational tracks for newly-hired graduate nurses. UMC will also conduct quality-improvement activities under these programs. UMC will assess the need for specialty services in its community, and use these nurse training programs as one means to begin meeting such identified needs.

Goals and Relationship to Regional Goals:

Project Goals: Under this project, UMC El Paso will focus on improving overall retention of nurses. UMC will also focus on realizing improvements in confidence, competency, organization and prioritization abilities, communication skills, leadership, and reduction in stress levels for nurses. All these improvements will result in highly-specialized and better patient care for UMC's entire patient population, especially the high number of underserved and unfunded patients which UMC regularly treats. Current initiatives at UMC include renovation to streamline our specialty services on the units and provide greater access to new diagnostic

services for our unfunded population not having this access in the past. Specialized physicians and nurses are part of this goal.

This project meets the following regional goals: This project meets the regional goal of increasing the number of specialists and scope of services offered in the community. This project will increase specialty services by expanding residency programs for specialty areas of identified need, thus bringing more specialty providers to the region.

Challenges:

A major challenge facing the implementation of this project is the high turnover rate for graduate nurses at UMC El Paso.

5-Year Expected Outcome for Provider and Patients:

UMC expects that the establishment of these nurse training programs will raise the retention rate for graduate nurses within the first two years of hire by 3%. UMC also expects that this project will improve TCS nursing services within these programs. Patients will receive highly competent care as a result of specialty trained nurses, enabling early identification of potential problems for patients through their expertise.

Starting Point/Baseline:

In 2010, the turnover rate for graduate nurses employed at UMC El Paso was 44%; a total of 16 graduate nurses were hired and 7 have left the organization. In 2011, the turnover rate for graduate nurses employed at UMC El Paso was 44%; a total of 36 graduate nurses were hired and 16 have left the organization. In 2012, the turnover rate for graduate nurses employed at UMC El Paso since January is 18%; a total of 16 graduate nurses were hired and 3 have left the organization to date.

Rationale:

The Institute of Medicine (IOM) has developed eight recommendations on improving the future of healthcare. The IOM states, "Nurses are going to have a critical role in the future, especially in producing safe, quality care and coverage for all patients in our health care system." IOM recommendation three is a recommendation that hospitals and educators implement nurse residency programs. The IOM believes that State Boards of Nursing, accrediting bodies, the federal government, and health care organizations all ought to support nurses in transitioning into new clinical practice areas.

UMC El Paso's nurse residency programs will be established to assist new graduate nurses seeking on-the-job training to transition into the profession of nursing in the hospital acute care setting. Through formal, clinical, and simulation training built on an evidence-based curriculum, the nurse residency program will focus on strengthening proficiency in highly specialized care, even more importantly, ensuring the effectiveness of each nurse's role in patient safety and patient outcomes.

Project Components: 1.9.3 "other" project options: Implement evidence-based Nurse Residency Program for Specialty Care

a) UMC will identify high impact / most impacted specialty services under current streamlining and renovation of the hospital focused on specialty care needs.

- This program will target the current and new streamlined specialty services and provide specific training to the nurse graduates enabling them to insert directly into the specialist environment.

b) Increase number of 'Specialists' trained graduate nurses

- Current needs in specialty care at UMC will be the initial curriculum, and will expand with UMCs expansion of specialty services.
- As new services are added at UMC (diagnostic, Endoscopy Suite, Neurology Center of Excellence, to name a few), additional nurses will accommodate this and have the specialized skills required

c) Conduct quality improvement for projects 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.

- UMC will conduct quality improvement activities as part of the programs established under this project.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care

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

This project will significantly enhance UMC's efforts to train nurses and recruit and/or retain them in the El Paso community. Because these new nurse residency and training programs will increase the likelihood that new graduates will choose to practice their specialties in El Paso, and that graduate nurses will remain in El Paso, this project will significantly enhance UMC's ability to train, recruit, and retain new mid-level specialty providers to serve patients in the region. This program will also provide for more timely and accurate treatment to our patients, thus leading to reduced lengths of stay and preventing readmissions. Reduced lengths of stay will offer additional bed space for our patients that need to be admitted. For outpatient diagnostic procedures, these nurses will be providing and assisting in the treatment of unfunded patients who do not currently have access to early detection through diagnostic testing.

Related Category 3 Outcome Measures:

OD-14 Workforce Projects
TSC Nurse Residency and Simulation Lab Program
IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA), or medically underserved area (MUA)
IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
Current RN turnover is 18%, National average is 14%, UMC wishes to meet the national average of 14%.

Reasons/rationale for selecting the outcome measures:

El Paso is considered a medically underserved area and retention of an adequate staff for specialized nursing and physicians is of utmost concern in order to provide quality patient care. As a result of this expanded Nurse Residency program, UMC expects that a greater number of nurse graduates will remain in Region 15, and more specifically, the El Paso Area. While it is understandable that many physicians choose to practice in areas with a higher percentage of insured, paying patients, UMC expects that after completing the nurse residency in a high-quality facility, the experience will make a difference to those patients that need it most – the uninsured and Medicaid population.

Relationship to other Projects: UMC has several other projects dedicated to expanding access to primary or specialty care, including Establishing the Crossroads Clinic in South-western El Paso (138951211.1.3); Enhancing Quality Improvement in the UMC NHCs (138951211.1.7); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4), Physician Residency (138951211.1.1**).**

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary or specialty care in the community. TTUHSC is developing a residency project that will complement UMC's nurse residency project.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the costs and health complications that can be avoided when a patient population receives the right care in the right setting, rather than being forced to utilize the Emergency Department as its primary healthcare resource. This project will significantly address the needs of the El Paso community by increasing the capacity to provide specialty care services to better accommodate the high demand for specialty care services so that patients have increased access to specialty services.

138951211.1.6	***1.9.3***	138951211.1.9.1	***NURSE RESIDENCY PROGRAM AND SIMULATION LAB***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-14	***IT-14.6 IT-14.7 IT-14.8***	138951211.3.6 138951211.3.20 138951211.3.21	***Workforce 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-1]: Conduct specialty care gap assessment based on community need. Metric [P-1.1]: Documentation of gap assessment. Baseline/Goal: Completion of gap assessment. Data Source: Needs assessment. Milestone 1 Estimated Incentive Payment: $1,272,849 **Milestone 2** [CQI P-19]: 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. Baseline/Goal: 2/month Metric [P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. 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	**Milestone 3** [P-2]: 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. **Numerator:** Number of staff and providers trained and documentation of training materials **Denominator**: Total number of staff and providers working in specialty care. Baseline: 15 new Graduate Nurses will be trained on processes, guidelines, and technology in their specialty areas: Emergency Department, Intensive Care, Neuro Intensive Care, Cardiovascular Intensive Care, Geriatrics, Trauma, Perioperative Services, (to include Endoscopy, Recovery, Post Anesthesia Care Unit and the Operating Room), Telemetry, Medical/Oncology, Surgical/Orthopedics, Labor & Delivery and Maternal/Infant Units. The graduates from the Nurse Residency Program will provide care to		**Milestone 5** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Baseline/Goal: Increase number of TSC Graduate Nurses attending the Nurse Residency at UMC by 20% over DY2 baseline. 18 new Graduate Nurses will be trained on processes, guidelines, and technology in their specialty areas: Emergency Department, Intensive Care, Neuro Intensive Care, Cardiovascular Intensive Care, Geriatrics, Trauma, Perioperative Services, (to include Endoscopy, Recovery, Post Anesthesia Care Unit and the Operating Room), Telemetry, Medical/Oncology, Surgical/Orthopedics, Labor & Delivery and Maternal/Infant Units. The graduates from the Nurse Residency Program will provide care to the following number of patients who will benefit from the education received in the Nurse Residency	**Milestone 6** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Baseline/Goal: Increase number of TSC Graduate Nurses/Nurse Techs attending the Nurse Residency and Nurse Tech Programs at UMC by 10% over DY4 baseline. 20 new Graduate Nurses will be trained on processes, guidelines, and technology in their specialty areas: Emergency Department, Intensive Care, Neuro Intensive Care, Cardiovascular Intensive Care, Geriatrics, Trauma, Perioperative Services, (to include Endoscopy, Recovery, Post Anesthesia Care Unit and the Operating Room), Telemetry, Medical/Oncology, Surgical/Orthopedics, Labor & Delivery and Maternal/Infant Units. The graduates from the Nurse Residency Program will provide care to the following number of patients who will benefit from the education received in the Nurse Residency Program:

138951211.1.6	***1.9.3***	138951211.1.9.1	***NURSE RESIDENCY PROGRAM AND SIMULATION LAB***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-14	***IT-14.6 IT-14.7 IT-14.8***	138951211.3.6 138951211.3.20 138951211.3.21	***Workforce 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 2 Estimated Incentive Payment: $1,272,849	the following number of patients who will benefit from the education received in the Nurse Residency Program: **ED/Trauma-3 new hires (2:1)=** 280 pts/year/hire x 3=840 pts/year **Intensive Care Units-3 new hires (2:1)** =280 pts/year/hire x 3= 840 pts/year **Perioperative Services-2 new hires (1:1)** = 140 pts/year x 2 =280 pts/year **Telemetry-2 new hires (4:1)** = 560 pts/year x 2 =1120 pts/year **Medical/Surgical/Geriatric-3 new hires (6:1)** = 840 pts/year x3 =2520 pts/year **Labor & Delivery-1 new hire (2:1)** = 140 pts/year **Maternal/Infant-1 new hire (4:1)** = 560 pts/year Total patients seen by Nurse Residents/year = 4,620 patients		Program: **ED/Trauma-3 new hires (2:1)=** 280 pts/year/hire x 3=840 pts/year **Intensive Care Units-4 new hires (2:1)** =280 pts/year/hire x 4= 1120 pts/year **Perioperative Services-3 new hires (1:1)** = 140 pts/year x 3 = 420 pts/year **Telemetry-2 new hires (4:1)** = 560 pts/year x 2 =1120 pts/year **Medical/Surgical/Geriatric-4 new hires (6:1)** = 840 pts/year x 4 = 3360 pts/year **Labor & Delivery-1 new hire (2:1)** = 280 pts/year **Maternal/Infant-1 new hire (4:1)** = 560 pts/year Total patients seen by Nurse Residents/year = 7,700 patients	**ED/Trauma-5 new hires (2:1)=** 280 pts/year/hire x 5=1400 pts/year **Intensive Care Units-4 new hires (2:1)** = 280 pts/year/hire x 4= 1120 pts/year **Perioperative Services-3 new hires (1:1)** = 140 pts/year x 3 =420 pts/year **Telemetry-2 new hires (4:1)** = 560 pts/year x 2 =1120 pts/year **Medical/Surgical/Geriatric-4 new hires (6:1)** = 840 pts/year x 4 =3360 pts/year **Labor & Delivery-1 new hire (2:1)** = 280 pts/year **Maternal/Infant-1 new hire (4:1)** = 560 pts/year Total patients seen by Nurse Residents/year = 8,260 patients

138951211.1.6	***1.9.3***	138951211.1.9.1	***NURSE RESIDENCY PROGRAM AND SIMULATION LAB***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-14	***IT-14.6 IT-14.7 IT-14.8***	138951211.3.6 138951211.3.20 138951211.3.21	***Workforce 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)**
	(Ratio/day x 7 days x 20 pay periods = pts/year) Data Source: Log of specialty care personnel trained and curriculum for training. Milestone 3 Estimated Incentive Payment: $1,388,610 **Milestone 4** [CQI P-19]: 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 1 **[**P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Goal: 2/month 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		(Ratio/day x 7 days x 20 pay periods = pts/year) Data Source: Nurse Graduate Residency schedule and daily staff assignments. Milestone 5 Estimated Incentive Payment: $2,785,293	(Ratio/day x 7 days x 20 pay periods = pts/year) Data Source: Nurse Graduate Residency schedule and daily staff assignments. Milestone 6 Estimated Incentive Payment: $2,300,894

138951211.1.6	***1.9.3***	138951211.1.9.1	***NURSE RESIDENCY PROGRAM AND SIMULATION LAB***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-14	***IT-14.6 IT-14.7 IT-14.8***	138951211.3.6 138951211.3.20 138951211.3.21	***Workforce 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 4 Estimated Incentive Payment: $1,388,610			
Year 2 Estimated Milestone Bundle Amount: $2,545,698	Year 3 Estimated Milestone Bundle Amount: $2,777,220		Year 4 Estimated Milestone Bundle Amount: $2,785,293	Year 5 Estimated Milestone Bundle Amount: $2,300,894
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $10,409,105				

93659

Project Option 1.10.3 Enhance improvement capacity within systems: **ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY AT UMC NEIGHBORHOOD HEALTH CENTERS**

Unique Project ID: 138951211.1.7
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso.

Intervention: UMC will document the improvement in the quality of care at its neighborhood health centers (NHCs) by upgrading the EMR system to be able to electronic prescribe medications, meeting meaningful use standards, and tracking HEDIS measures for higher quality care and better documentation. UMC will add key staff to enhance and interpret reporting methodologies that enable quality improvement and rapid-cycle change. The EMR upgrade and staff will give UMC the ability to capture and track data and provide a scorecard to measure improvement.

Need for the Project: UMC's neighborhood health centers (NHCs) are currently using an older version of NextGen EMR and are unable to implement electronic prescribing, obtain meaningful use status, or create a dashboard of HEDIS measures without upgrading this system. The NHCs have no dedicated staff for meaningful use implementation, and they have access on a limited basis to quality assurance staff members who are shared with the hospital.

Target Population: UMC expects that its neighborhood health centers (NHCs) will expand their quality improvement capacity through the development and increase of people, processes, and technology, so that the resources are in place to conduct, report, drive, and measure quality improvement, ensuring better health outcomes for the patients served by the NHCs.

Category 1 or 2 expected patient benefits: Implement quality improvement data systems, collection, and reporting capabilities. Increase the number of reports generated through these quality improvement data systems. Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures. We expect this project to improve the quality of care given for the 41,305 patient visits in Y2, 49,500 patient visits in Y3, 57,000 patient visits in Y4 and 63,500 patient visits in Y5 for a total of 211,305 visits.

Category 3 Outcomes: IT-12.6 Other Outcome Improvement Measure: Hemoglobin A1c Measurement: reduce Hemoglobin A1c Measurements in patient discharged to the NHCs to below 8% within 1 year.

- DY4 goal: have 40% of the patients have a HbA1c less than 8% after 1 year in the program
- DY5 goal: have 50% of the patients have a HbA1c less than 8% after 1 year in the program

- **Project Description:**

This project will allow UMC to document the improvement in the quality of care at its neighborhood health centers (NHCs).

UMC will document the improvement in the quality of care at its neighborhood health centers (NHCs) by upgrading the EMR system to be able to electronic prescribe medications, meeting meaningful use standards, and tracking HEDIS measures for higher quality care and better documentation. UMC will add key staff to enhance and interpret reporting methodologies that enable quality improvement and rapid-cycle change. The EMR upgrade and staff will give UMC the ability to capture and track data and provide a scorecard to measure improvement.

Goals and Relationship to Regional Goals:

Project Goals: UMC's neighborhood health centers (NHCs) will intensify their quality improvement programs and upgrade their electronic medical records systems to be able to qualify for Meaningful Use federal Medicare and Texas Medicaid standards. UMC's NHCs will also begin to prescribe medications electronically, which will result in better coordination of care and enhanced quality of patient care. UMC will develop increased quality performance measures and decision support so that cost, access, and quality are measurable and improvement can be demonstrated at the NHCs.

This project meets the following regional goals: This project meets the regional goal of increasing patient satisfaction through delivery of high-quality, effective healthcare services. This project will meet this goal by establishing or improving quality improvement systems at UMC's neighborhood health centers (NHCs) in order to provide a higher quality of healthcare services at the NHCs.

Challenges:

The challenges UMC will face involve technical changes to the provision of care at UMC's neighborhood health centers (NHCs); the expansion of staff and of staff knowledge and interaction with the EMR; and the implementation of the necessary requirements to acquire Meaningful Use Certification for all NHC sites. Coordination and training for the staff of the NHCs, as well as integration with the upgraded EMR system, will be required. Training of staff

and appropriate documentation must be provided to state and federal officials in order for the NHCs to be granted meaningful use status.

5-Year Expected Outcome for Provider and Patients:

UMC expects that its neighborhood health centers (NHCs) will expand their quality improvement capacity through the development and increase of people, processes, and technology, so that the resources are in place to conduct, report, drive, and measure quality improvement, ensuring better health outcomes for the patients served by the NHCs. Patients with Diabetes will be healthier and their HbA1c will be in much tighter control.

Starting Point/Baseline:

UMC's neighborhood health centers (NHCs) are currently using an older version of NextGen EMR and are unable to implement electronic prescribing, obtain meaningful use status, or create a dashboard of HEDIS measures without upgrading this system. The NHCs have no dedicated staff for meaningful use implementation, and they have access on a limited basis to quality assurance staff members who are shared with the hospital. While we offer some diabetic education we have no diabetic program reaching every diabetic patient

Rationale:

The necessity for improved quality and safety initiatives is ever present. Organized and documented performance improvement processes and effective reporting of the results are critical to make and sustain appropriate changes. Skilled staff and effective technology are vital to insure that our health care system is providing optimum patient health outcomes.

Project Components:

This project will accomplish the following project components:

a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
    - UMC will train the relevant staff on the use of the quality improvement infrastructure as part of the implementation of that infrastructure.

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.
    - UMC will develop and implement an employee suggestion system at its neighborhood health centers (NHCs).

c) Conduct quality improvement for the project using methods such as rapid cycle improvement. 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.

- UMC will use its new quality improvement infrastructure, after implementation, to conduct quality improvement activities at its neighborhood health centers (NHCs).

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-6: Other Projects

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

This project will significantly enhance the care provided to El Paso residents through UMC's neighborhood health centers (NHCs), by improving the quality of the care provided at the NHCs. Currently, these NHCs are unable to undertake meaningful quality improvement activities due to a lack of staff, technology, and other infrastructure.

Reasons/rationale for selecting the outcome measures:

This improvement measure was chosen because it complements the purposes of this quality improvement project. In order to effectively reduce a diabetes patient's Hemoglobin A1c, the patient should have access to quality care, effective follow-up instructions, medication management, and consistent screening. A reduction of a patient's Hemoglobin A1c measurement shows improvement in managing this chronic disease. Because the purpose of the project is ultimately to improve the quality of primary care provided at the NHCs, this outcome measure will help track whether or not the project has been successful in its goal, which is to increase quality of care and positively affect patient outcomes.

Relationship to other Projects: This project is one of several UMC projects which aim to improve the quality and availability of primary care services in the El Paso community, including Establishing the Crossroads Clinic in Southwestern El Paso (138951211.1.3); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing

to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which improved quality improves patient outcomes. The necessity for improved quality and safety initiatives is ever present. Organized and documented performance improvement processes and effective reporting of the results is critical to make and sustain appropriate changes. Obtaining Meaningful Use Status helps ensure a level of clinical competence. Skilled staff and effective technology are vital to insure that our health care system is providing optimum patient health outcomes by our patients receiving more effective, quality care.

138951211.1.7	***1.10.3***	1.10.3 a-b	***ENHANCE IMPROVEMENT CAPACITY WITHIN SYSTEMS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD – 12 Primary Care and Primary Prevention	***IT-12.6 Other Outcome Improvement Target: Hemoglobin A1c***	138951211.3.7	***Other Outcome Improvement Target: Hemoglobin A1c Measurement***

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-6]:Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools, and processes, such as rapid-cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends). Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles. Baseline/Goal: 10% increase in number of staff over DY1. Data Source: HR; training programs. Milestone 1 Estimated Incentive Payment: $452,569 Milestone 2 [P-5]: Enhance or expand the organizational infrastructure and resources to store, analyze and share quality measures data as well as utilize them for improvement. Metric 2 [P.5-1] Increase collections of quality measures data.	**Milestone 4** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities. Metric 4 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline/Goal: 2, goal is to add 2 new reports **Expected patient benefit**: improve the quality of care given for the 49,500 patient visits in DY3 Data Source: Quality improvement data systems. Milestone 4 Estimated Incentive Payment: $740,592 **Milestone 5** [CQI P-8]: 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.	**Milestone 6** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities. Metric 4 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline/Goal: 4, goal is to add 2 new reports **Expected patient benefit**: improve the quality of care given for the 57,000 patient visits in DY3 Data Source: Quality improvement data systems. Milestone 6 Estimated Incentive Payment: $1,485,490	**Milestone 7** [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures. Metric 6 [I-8.1]: Submission of quality dashboard or scorecard. Baseline/Goal: Creation and sharing of one quality dashboard or scoreboard. **Expected patient benefit**: improve the quality of care given for the 63,500 patient visits in DY4 Data Source: Quality Improvement Data Systems Milestone 7 Estimated Incentive Payment: $1,227,144

138951211.1.7	***1.10.3***	1.10.3 a-b	***ENHANCE IMPROVEMENT CAPACITY WITHIN SYSTEMS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD – 12 Primary Care and Primary Prevention	***IT-12.6 Other Outcome Improvement Target: Hemoglobin A1c***	138951211.3.7	***Other Outcome Improvement Target: Hemoglobin A1c Measurement***	
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 / goal is to add 2 new reports **Expected patient benefit:** improve the quality of care given for the 41,305 patient visits in Y2 Data Source: Documentation of quality measures data collection and reporting. Milestone 2 Estimated Incentive Payment: $452,569 **Milestone 3** [CQI P-8]: 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 3 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: n/a Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or	Metric 5 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. 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. Goal: Hold two meetings per month Milestone 5 Estimated Incentive Payment: $740,592			

138951211.1.7	***1.10.3***	1.10.3 a-b	***ENHANCE IMPROVEMENT CAPACITY WITHIN SYSTEMS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD – 12 Primary Care and Primary Prevention	***IT-12.6 Other Outcome Improvement Target: Hemoglobin A1c***	138951211.3.7	***Other Outcome Improvement Target: Hemoglobin A1c Measurement***	
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)**
webinars, including agendas for phone calls, slides from webinars, and/or meeting notes. Baseline: 0 meetings Goal: Hold two meetings per month Milestone 3 Estimated Incentive Payment: $452,568				
Year 2 Estimated Milestone Bundle Amount: $1,357,706	Year 3 Estimated Milestone Bundle Amount: $1,481,184		Year 4 Estimated Milestone Bundle Amount: $1,485,490	Year 5 Estimated Milestone Bundle Amount: $1,227,144
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,551,523				

93651

Project Option 1.9.3 Expand Specialty Care: **Placing Behavioral Health Trained Psychiatric Practitioners into a Non-Behavioral Health Institution.**

Unique Project ID: 138951211.1.8
Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs. Region 15 has a severe shortage of behavioral healthcare services available in the community. Behavioral health facilities currently operate above-capacity, and Performing Providers in the Region continue to struggle to provide adequate behavioral healthcare to patients.

In 2012, 7478 patients with a secondary behavioral diagnosis were admitted either to a Medical or Surgical unit. The rate of consultations was approximately 600 annually. The ultimate goals of the psychiatric liaison are 1.) Early identification and management of behavioral health needs 2.) Decrease the length of stay for those patients requiring focused management. 3.) Facilitate the transition process to outpatient psychiatric services through the Local Mental Health Agency (LMHA).

The objective is to develop and expand a well coordinated mental health program that will serve those with limited or no resources. UMC plans to employ a fulltime psychiatric liaison and two full-time social workers. Together, this team will progressively offer well coordinated psychiatric services to inpatients with a secondary behavioral diagnosis. The psychiatric liaison team will make an impact as follows:

1. DY3 team will identify and interview 4 patients/ day x2 social workers = 8 interviews/ day. 2160/ year.

2. DY4 team will identify and interview 5 patients / day x2 social workers = 10 interviews/ day. 2700/year.

3. DY5 team will identify and interview 6 patients / day x2 social workers = 12 interviews/ day. 3240/ year.

Intervention(s): This is a new program for UMC. This project will create a specific psychiatric liaison service for patients who are admitted with medical conditions and also have a behavioral health related diagnosis. This program will also evaluate the need for additional psychiatrist service options in the hospital. This project will also identify patients who need ongoing

behavioral health treatment and ensure these patients are consulted with the LMHA (i.e. those patients who may not otherwise be identified for behavioral health needs).

Need for the project: This early identification of current behavioral needs during the patient's medical admission will better accommodate the patient by treating those needs via the Psychiatric Liaison while the patient is in-house. We plan to identify and treat current behavioral health needs of our inpatients, as there is no qualified expert at this time to do this. Also, we will begin addressing their ongoing needs early in the admission process to provide timely behavioral health services as outpatients via our LMHA. We will also identify behavioral health patients who currently may not be identified during the hospital stay.

Target population: The target population will be admitted patients for primary medical conditions who also have a secondary or related diagnosis of a behavioral health condition.

Category 1 or 2 expected patient benefits: The expected benefit to the patient of this project is to identify and treat UMC's patients who are admitted and also have behavioral health diagnosis that need this secondary diagnosis controlled in an effective manner so as not to exacerbate their behavioral health condition while being treated for a medical condition at UMC. The goal is to prevent unnecessary readmissions to the ER for behavioral conditions left untreated, and to communicate and coordinate timely treatment for this patient population once the patient's condition is stabilized and treated in the hospital.
Category 3 outcomes: The measurement goal for this project falls in the category of OD-11 Addressing Health Disparities in Minority Populations IT-11.5; IT-3.1: All-cause 30-day readmission rate—25% improvement over established baseline during the first year of this project through DY5 for target population.

Project Description:

This project will take a multi-faceted approach to increasing and improving behavioral health care to patients at UMC.

One important step in implementing this project is establishing a program to provide inpatient psychiatric care to patients who are awaiting placement at the El Paso Psychiatric Center, including partnering with private psychiatric facilities to accept UMC patients on a limited basis. Additionally, UMC will provide inpatient psychiatric consultative services to hospital inpatients during the treatment of their medical/surgical conditions, and will establish the use of a Psychiatric Liaison in the hospital setting to serve as a link for both nursing and patient issues.
The first part of auditing the effects of this project involves scrutinizing patient demographics; assessing whether patients are known to have psychiatric diagnoses; reviewing time of arrival to inpatient unit, waiting time on unit, duration of contact with patient, and whether the patient was regarded as having an emergency (seen immediately), urgent (seen within one hour), or non-urgent (seen within one day); diagnosis of each referral, and, just as important, potential costs savings due to reduced patient sitter usage and reduced hospital length of stay (LOS) and associated reimbursement. Finally, data will be reviewed and compared in order to determine if the project is having an effect on Emergency Department throughput.

Goals and Relationship to Regional Goals:

Project Goals: Implement a holistic approach to treating inpatients at the hospital, to include their psychiatric/behavioral treatment needs. This will improve stabilization time for patients awaiting transfer to El Paso Psychiatric Center, and will improve early detection of psychiatric issues for medical/surgical inpatients.

This project meets the following regional goals: This project meets the regional goal of enhancing and expanding behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care. This project will meet this goal by establishing an inpatient psychiatric care program, providing inpatient psychiatric consultative services to hospital inpatients, and establishing a psychiatric liaison in the hospital.

Challenges:

UMC will face challenges in hiring and training the requisite staff to provide psychiatric care in an inpatient hospital setting. Another challenge associated with this project is that of coordinating care decisions and treatment plans between medical, surgical, and psychiatric providers, and incorporating psychiatric consultations into the surgical/medical care model.

5-Year Expected Outcome for Provider and Patients:
We expect to see an improvement in the stabilization time and short-term treatment for patients awaiting transfer to El Paso Psychiatric Center, an improvement in the early detection of psychiatric issues for medical/surgical inpatients, and better coordination of providers and patients through a trained psychiatric nurse.

Starting Point/Baseline:

Many patients awaiting transfer from UMC to El Paso Psychiatric Center are in various stages of being suicidal, homicidal, or otherwise incapacitated due to psychiatric/behavioral conditions. It is crucial, both for cost efficiency and overall health outcomes, that patients receive psychiatric treatment while inpatients at UMC. Providing specialized psychiatric care at the hospital will lessen the amount of time it takes for a patient to be stable enough to transfer, and will likely prevent further deterioration while awaiting transfer. Likewise, many medical/surgical inpatients are in need of psychiatric care, and early detection of these treatment needs while the patient is hospitalized will prevent the need for more expensive interventions in the future when the psychiatric condition may be triggered or exacerbated. Currently, UMC does not have adequate specialized staff (including psychiatrists, mid-levels, or psychiatric nurses) available at the hospital to provide these treatments/consultations. The best method to determine the effectiveness of the Psychiatric Liaison is to conduct a retrospective cohort review followed by a prospective study. First, the retrospective method will look backwards and examine the relationship between those patients who have documentation indicating a specific factor (psychiatric diagnosis) in relation to a specific outcome. For example, Length of stay, sitter usage and those other factors previously mentioned. Second, the prospective study will observe for outcomes during a predetermined time period and relate the findings to the implementation of the NLS. The prospective study evaluates the effects of the health care intervention, in which

cohorts are divided into groups that are exposed to Psychiatric Liaison service or not exposed to the intervention of interest. In other words, it is an analytic design to determine the relationship between a condition and a characteristic shared by some members of a particular group.

Rationale:

Mental illness and mental problems, including those of people with learning difficulties, occur in patients of all ages and of different racial, religious and cultural backgrounds. Their problems take many different forms, and different patients bring a variety of specialized needs. Often these needs are clinical and medical, but almost always reach into family, social or working life. Broneheim and colleagues (1998) state than in the general medical setting, as many as 30% of patients have a psychiatric disorder. For this reason, it is often very difficult to have the specialty service needed to treat these unique patients, even in teaching hospitals like University Medical Center (UMC), or for non-specialist staff to be in a position to call in the appropriate specialist help. Sharrock and Happell (2002) explain that there is a growing body of evidence to suggest that nurses working in general hospital settings do not generally consider themselves adequately prepared, skilled or experienced to care for patients with mental health problems whether the symptoms are chronic or secondary to an acute illness. For that reason, the services of an inpatient Psychiatric Liaison are in dire need at UMC. Psychiatric Liaison Services are an essential part of a whole acute service, ready to respond at any time, to draw in the specialist expertise appropriate to the problem and to arrange the necessary collaboration within, between, and beyond the hospital stay. The Psychiatric Liaison will have an important role in supporting staff nurses and other health care professionals in caring for patients experiencing mental health problems in the non-psychiatric environment.
Many people can develop mental health problems during major changes in physical health which escalate without intervention. Timely preventive measures and health education can reduce demand on services and greatly improve the quality of life for the patient. Many people experience mental health related issues but have limited or no access to services when these problems are related to physical health treated in the general hospital setting. Consultant physicians are not qualified to provide brief interventions and self-help, primary care has limited capacity, and patients are often not ill enough to qualify for secondary mental health services. El Paso, Texas is severely lacking in resources for the treatment of mental health, developmental disability and related mental health conditions. Many psychiatric patients in the El Paso region are unfunded. The establishment of a psychiatric liaison service will improve the health outcomes of people with chronic and major physical health problems by addressing debilitating mental health issues, reduction in re-admission rates to acute inpatient units, and prevention of escalation of mental health illness events.

Project Components/Project Option: 1.9.3 Other Project Option: Inserting Behavioral Health Trained Practitioners into a Non-Behavioral Health Institution

This project will accomplish the following project components:

- UMC will establish the use of a psychiatric liaison in the hospital setting to serve as a link for both nursing and patient issues and to provide services to these patients as necessary during their stay for medical / surgical condition.

- UMC will establish guidelines to identify patients that have behavioral health conditions to gain access to the behavioral health system. This will identify and provide necessary care to behavioral health patients who may not be enrolled through the LMHA currently, as well as enhance services to current patients enrolled with the LMHA with urgent timely care (outpatient discharge needs, medications, etc.).

- UMC will arrange for continuing services, early in the admission process, to be provided to these patients via the LMHA, ensuring a more efficient and timely process than we currently have.

- UMC will provide inpatient physician psychiatric consultative services to hospital inpatients during the treatment of their medical/surgical conditions, and evaluate the need for additional hours under the current contract, or adding an additional consultative Psychiatrist(s).

Unique community need identification numbers the project addresses:

- CN.2 Secondary and Specialty Care

- CN.5 Behavioral Health

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

This project will significantly increase the resources available for psychiatric treatment of inpatients at UMC. Rather than treating patients' medical conditions and psychiatric conditions separately (which most likely leads to sub-par care for one of those conditions), this project will reform the delivery system by allowing UMC inpatients to receive a greater degree of psychiatric care at the same time as they receive the medical care for which they were admitted to the hospital.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations
IT-11.5; IT-3.1: All-cause 30-day readmission rate—10% improvement over DY3 for target population discharged from UMC
IT-11.5; IT-3.1: All-cause 30-day readmission rate—15% improvement over DY4 for target population

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the improvement in patient outcomes for patients receiving the inpatient psychiatric care that will be made available by this project and managed by the psychiatric liaison. UMC believes that this project will result in improved patient outcomes because these patients will be receiving the psychiatric care they need when and where they need it. In DY3, UMC will determine the improvement target quantification.

Relationship to other Projects: This project is one of several UMC projects which aim to improve the quality and scope of inpatient services at UMC, including UMC's Hospital-Wide Nurse Advice Line project, Quality EMR Databases project, and Specialized Nursing project

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: HCA Las Palmas is developing a Psychiatric Telemedicine program that will expand access to psychiatric care for patients in the El Paso community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which the provision of inpatient psychiatric services at UMC will address the community needs, the population served, resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because psychiatric services will be available under this project to patients when and where they need it, thereby reducing psychiatric complications and reducing the likelihood of readmission. Additionally, providing these services at the appropriate time makes it more likely that a patient's mental health problems will be addressed before greater complications can develop, leading to better outcomes and less costly treatment.

138951211.1.8	*1.9.3*	1.9.3	IMPLEMENT OTHER EVIDENCE-BASED PROJECT	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD - 11	***IT-11.5 (IT-3.1)***	138951211.3.8	Addressing Health Disparities in Minority Populations IT-11.5; IT-3.1: All-cause 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-1]: Conduct gap analysis. Metric 1 [P-1.1]: Baseline analysis of behavioral health patient population, which may include elements such as consumer demographics, proximity to sources of specialty care, utilization of Emergency Department , other crisis and inpatient services including state hospital services used by residents of the region, incarceration rates, most common sites of mental health care, most prevalent diagnoses, co-morbidities; existing provider caseload, provider demographics and other factors of regional significance. Baseline/Goal: 1-Conduct gap analysis. 2-We estimate annual number of inpatient psychiatric consultations performed to be 600 annually. 3-Establish current referrals and /or consultations for referrals from the units to LMHA Data Source: HPSA data; provider licensing and enrollment data from	**Milestone 3** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into medical specialties Metric 1 [P-2.1]: Training of nursing staff and physicians in the ED and on the units on referral guidelines, processes and technology Numerator: Number of staff and physicians on unit and ED trained in guidelines Denominator: Total number of staff and physicians on unit and ED Baseline/Goal: 1-Hire Psychiatric Liaison(s) and 2- qualified social workers. Evaluate need for additional staff to include psychiatrists. 2-Ongoing training of all staff and physicians that work in ED and on units at any given time (since Residents rotate Data Source: Curriculum, protocols,	**Milestone 5** [I-23]: Increase behavioral health services for our inpatients Metric 1 [I-23.2]: Documentation of increased number of behavioral health patients receiving care via Psychiatric Nurse Liaison Total number of behavioral health patients encountered for reporting period Baseline/Goal: 10% improvement over DY3. Identify and interview 5 patients/ day x2 social workers = 10 interviews/ day. 2700/ year. Data Source: Registry, Log. EMR. Milestone 5 Estimated Incentive Payment: $2,599,607	**Milestone 6** [I-29]: Increase the number of referrals to LMHA from the hospital units Metric 1 [I-29.1]: Targeted Referral Rate Number of referrals of hospital inpatients to LMHA Baseline/Goal: 10% improvement over DY4. Identify and interview 6 patients/ day x2 social workers = 12 interviews/ day 3240/ year. Data Source: Registry, Log. EMR Milestone 6 Estimated Incentive Payment: $2,147,501

138951211.1.8	***1.9.3***	1.9.3	IMPLEMENT OTHER EVIDENCE-BASED PROJECT	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD - 11	***IT-11.5 (IT-3.1)***	138951211.3.8	Addressing Health Disparities in Minority Populations IT-11.5; IT-3.1: All-cause 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)
state and local sources; claims and encounters from regional and state data sources; provider and consumer survey, interview, and focus group data. Milestone 1 Estimated Incentive Payment: $1,187,993 **Milestone 2** [CQI P-19]: 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 1 [P-19.2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions successfully during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.	policies, and log of staff trained on identification of behavioral health conditions and consultations into program. Executed contract demonstrating service provided by Psychiatric Nurse Liaison. Milestone 3 Estimated Incentive Payment: $1,296,036 **Milestone 4** [CQI P-19]: 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 1 [P-19.2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions successfully during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during		

138951211.1.8	***1.9.3***	1.9.3	IMPLEMENT OTHER EVIDENCE-BASED PROJECT	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD - 11	***IT-11.5 (IT-3.1)***	138951211.3.8	Addressing Health Disparities in Minority Populations IT-11.5; IT-3.1: All-cause 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 2 Estimated Incentive Payment: $1,187,992	each bi-weekly interaction. Milestone 4 Estimated Incentive Payment: $1,296,036			
Year 2 Estimated Milestone Bundle Amount: $2,375,985	Year 3 Estimated Milestone Bundle Amount: $2,592,072		Year 4 Estimated Milestone Bundle Amount: $2,599,607	Year 5 Estimated Milestone Bundle Amount: $2,147,501
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,715,165				

93629

Project Option 1.1.4: Expand Primary Care Clinic Staffing: **PRIMARY CARE PHYSICIAN RECRUITMENT**

Unique Project ID: 094109802.1.1
Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will help improve our ability to recruit and retain physicians to the El Paso area by developing strategies for their recruitment and incentives for their growth and success. Examples of incentives include tuition assistance for residents and rotations in a private hospital setting.

Need for the project: The El Paso area is in immediate need of at least 60 positions related to primary care. Wait times in physician offices are lengthy, hospital lengths of stay are longer than necessary and patient rounding at hospitals is getting later and later for physicians whose patient load is heavy.

Target Population: The target population is the patient population with the need for a primary care physician, new families moving into the area and patients who are in need of maintaining their annual screenings. About 44% of our facility-wide patient population is Medicaid eligible or indigent. We expect that this project will reflect a similar benefit to Medicaid eligible or indigent patients.

Category 1 or 2 Expected patient benefits: The project seeks to recruit or employ at least 4 primary care physicians by DY4 and increase patient visits by approximately 10,800 over DY2 and recruit or employee an additional 2 physicians by DY5 for a total approximate increase in patient visits of 16,200 over DY2. This project will not directly serve patients in DY2 as this year will serve as focus on recruiting and preparing for improvements in patient benefits.

Category 3 outcomes: IT-6.1 Our goal is to improve the patient satisfaction scores by 2.5% over DY3 in DY4, and 5% over DY3 in DY5. The patient satisfaction increase would be a direct result of reaching more patients by adding more primary care providers. Our current shortage of providers is approximately 60 physicians which create long wait times and over utilization of emergency departments.

Project Description:

This project will increase recruitment and training of physicians and support staff including nurse practitioners and physician assistants.

Under this project, recruitment will entail creative strategies for attracting the needed practitioners to the El Paso community. We have an ongoing mission to draw talented, qualified physicians to our facility. We have actively engaged in marketing and incentive strategies to

recruit physicians into our community. In addition to current efforts, we continue to seek and develop innovative ways to attract physicians to El Paso. This project will improve our ability to retain and recruit physicians. We are in need of at least 60 positions within our community (including 25 Internal Medicine, 18 Family Practice, and 15 Pediatricians). In order to hire and retain these key personnel, we plan to recruit or employ them within a five-year period. We will develop a plan for adding additional incentives to the recruitment and retention efforts and implement strategies we have identified. It is our intention to provide physician resident rotations at our facility in cooperation with Texas Tech, so that their residents may experience treating patients in a private hospital setting. This will serve a dual purpose: area physicians will receive additional training, and we will have the opportunity to recruit them to stay at our El Paso facilities.

Goals and Relationship to Regional Goals:

Project Goals: The primary goal of this project is to increase the number of primary care physicians in the El Paso area, in order to improve access to primary care in the area.

This project meets the following regional goals: This project is tied to Region 15's goal of increasing the number of specialists and scope of services offered in the community by recruiting primary care physicians to El Paso. It is also tied to Region 15's goal of increasing access to primary care by increasing the primary care workforce through recruitment.

Challenges:

Challenges include: obtaining the staff ; implementing collaborations with education facilities; targeting practitioners willing to work in primary care and live in El Paso; offering competitive recruitment packages.

5-Year Expected Outcome for Provider and Patients:

By effectively increasing the primary care workforce of primary care professionals through recruitment , patients will have a better patient experience in the hospital setting. This better patient experience comes in the form of decreased wait times, decreased lengths of stay and more timely delivery of diagnoses and treatment. As a result of a better patient experience, hospitals and other healthcare providers will see improved patient satisfaction scores.

Starting Point/Baseline:

As of December 2011, our medical staff complement for HCA Las Palmas Del Sol is 282. This consists of 148 Internal Medicine, 88 Pediatricians, 46 Family Practice, and various others. Currently we offer income guarantees to physician recruits, including relocation and start-up support.

Rationale:

El Paso, Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce providers is a critical problem that we have the opportunity to begin addressing under this waiver.

It is difficult to recruit and hire primary care physicians. We are in need of at least 60 positions within our community (including 25 Internal Medicine, 18 Family Practice, and 15

Pediatricians). The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Nearly one-third of the El Paso community is uninsured or underinsured; many of these patients utilize the community emergency departments for primary care. This results in high-cost, fragmented healthcare delivery. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system. In summary, the goal for this project is to recruit more primary care providers in order to address the substantial primary care workforce shortage, increase access, care for the aging and uninsured population, and develop more organized care delivery models.

Project Components:

This project will accomplish the following project components:

a) Expand primary clinic space - clinic space will not be expanded because LPDS has the space.

b) Expand primary care clinic hours - the hours are sufficient, but more providers are needed during clinic hours.

c) Expand primary care clinic staffing - we will expand clinic capacity through the addition of 6 primary care providers.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care

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

This project represents an enhanced initiative already in practice at LPDS. Currently, we are recruiting various types of physicians every year, but are limited in funds and certain specialties.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT-6.1: Percent improvement over baseline of patient satisfaction scores

094109802.3.1

Reasons/rationale for selecting the outcome measures:

This project will increase the number of physicians and scope of services offered in the community by facilitating the recruitment of primary care physicians to the El Paso area. This increase in the primary care workforce will result in strengthen and integrated health care system and play a key role in implementing disease management programs. The goal of this project is to recruit more workforce members to serve as primary care providers and clinicians to address the substantial primary care workforce shortage.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. . Specifically, this project will complement LPDS's Psychiatric Telemedicine project (094109802.1.1) and Outpatient Women's Services Expansion project (094109802.1.2); each of these projects is intended to increase access to important health care services for patient populations with an identified need and an identified lack of timely access. Furthermore, this project will complement the Outpatient Women's Imaging Services Expansion project in developing and expanding a robust community-wide network of primary care services in El Paso.

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

UMC is also working to increase the number of physicians and mid-level providers in the El Paso area through its residency and nursing residency DSRIP projects.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$7,846,229. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the crucial role that primary care providers play in effectively and efficiently providing quality health care services to a community, and the need for such primary care providers in El Paso.

094109802.1.1	*1.1.4*	*1.1.4.C*	***PRIMARY CARE PHYSICIAN RECRUITMENT***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.1*	*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-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. Baseline/Goal: We currently have 282 primary care providers, and will increase by 1 provider. 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 1 Estimated Incentive Payment: $1,918,909	**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 1 [P-5.1] Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: We will increase by an additional 2 providers from DY2. 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 2 Estimated Incentive Payment: $1,046,713 **Milestone 3**: [I-12]. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: These providers have not been hired but so there are currently no primary care visits resulting from this project. We expect to increase by 8,100 with the additional 3 providers from (DY2 and DY3). Data Source: Registry, EHR, claims or other Performing Provider source Milestone 3 Estimated Incentive Payment: $1,046,713		**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patient seeking services Metric 1 [I-12.1]: Documentation of increase number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: We expect to increase by 2,700 patients visits as a result of 1 additional provider over DY3. Data Source: Registry, EHR, claims or other Performing Provider source Patient Impact – Total Patient visit increase over DY2 is 10,800 Milestone 3 Estimated Incentive Payment: $2,099,513	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patient seeking services Metric 1 [I-12.1]: Documentation of increase number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: We expect to increase by 5,400 patients visits as a result of 2 additional providers over DY4. Data Source: Registry, EHR, claims or other Performing Provider source Patient Impact – Total Patient visit increase over DY2 is 16,200 Milestone 4 Estimated Incentive Payment: $1,734,380
Year 2 Estimated Milestone Bundle Amount: $1,918,909	Year 3 Estimated Milestone Bundle Amount: $2,093,427		Year 4 Estimated Milestone Bundle Amount: $2,099,513	Year 5 Estimated Milestone Bundle Amount: $1,734,380
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,846,229				

95778

Project Option 1.1.1: Establish more primary care clinics: **OUTPATIENT WOMEN'S SERVICES EXPANSION**

Unique Project ID: 094109802.1.2
Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will expand the availability of women's services by establishing two additional Outpatient Women's Centers in DY2, and two additional Outpatient Women's Centers in DY3. The Outpatient Women's Centers offer services to women and teens, and provide pregnancy testing, primary care access, and information on prenatal care and healthy living. This project's goal is to reduce the percentage of low-weight births by offering outpatient women's services to those that cannot afford, or do not have access to a primary care physician. As a result of this intervention and partnership with primary care resources, these women will be able to access prenatal care much earlier in their pregnancy, which will result in better outcomes for the mother and baby. The goal of this project is to get women in the El Paso community the early interventions that can be so crucial in a healthy birth.

Need for the project: According to the March of Dimes, over 11% of live births in El Paso occur to mothers with late or no prenatal care. Early and consistent prenatal care is crucial in preventing many complications during pregnancy and increases the chances of carrying the baby to term and decreases the chances of birth defects. Many women in the community do not have access to a primary care physician because they are uninsured. The Outpatient Women's Center serves patients regardless of ability to pay and assists in setting up an appointment with a primary care physician that will see the patient, regardless of ability to pay, within 48 hours. In addition to these patient benefits, the benefit in cost savings to the healthcare delivery system is significant. A single Neo-natal Intensive Care Unit (NICU) case is about $22,000, and has a length of stay of just over 18 days. Low-weight births that could be prevented by prenatal care early in the pregnancy would result in a huge savings to the community, and allow other high-acuity births to have a bed available in the NICU, which has a limited capacity.

Target Population: The target population is women who are in need of women's services. . About 44% of our facility-wide patient population is Medicaid eligible or indigent. We expect that this project will reflect a higher percentage benefit to Medicaid eligible or indigent patients, because the high rates of late or no prenatal care typically come from the low income population.

Category 1 or 2 Expected patient benefits:
The current LPDS Outpatient Centers serve about 24,000 patients, but does not allow access to all areas of the community. We do not anticipate that any patients will be directly served in DY2, as LPDS will be establishing two new clinics, and develop plans to open two additional clinics in DY3. This project will increase access to Outpatient Women's services by about 4,000 patients over DY2 in DY3, 8,000 patients over DY2 in DY4, and 8,000 patients over DY2 in DY5. By

opening these 4 additional centers, LPDS hopes to reduce the percentage of low-weight births over the course of the Waiver.

Category 3 outcomes: IT-8.2 – Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) Our goal is to improve the percentage of low-weight births by 5% in DY4, and 10% in DY5 over the baseline established in DY3.

Project Description:

This project will expand the availability of the Women's Service Resource Centers and streamline processes within those centers.

This project will expand the availability of the Outpatient Women's Centers by opening two additional Centers in DY2, and two additional centers in DY3. This project will offer early access to prenatal care by developing an alignment strategy to provide a seamless referral process between the Outpatient Women's Centers and primary care physicians . This will also provide the patient with a better experience and allow them to be seen by a primary care physician within 48 hours of their Women's Center visit.

Goals and Relationship to Regional Goals:

Project Goals:

This project meets the following regional goals: This project is tied to Region 15's goal of increasing access to primary care . It is also tied to Region 15's goal of providing patient education to ensure the population is accessing the right care in the right setting by implementing community awareness and educational opportunities.

Challenges:

Currently, over 11% of the births in El Paso have either late or no prenatal care. This is caused by a lack of education, outreach, and access to primary care services early in pregnancy. This project will offer outpatient women's services, regardless of ability to pay, and will work to set each patient up with a primary care appointment with a community primary care physician within 48 hours of their visit to an Outpatient Women's Center.

5-Year Expected Outcome for Provider and Patients:

The 4 additional clinic locations will result in an increase of early intervention and access to prenatal care, which LPDS hopes will have an impact on the percentage of low birth weight seen at its facility. Early access to prenatal care and other primary care services will allow low-income women a better chance at a healthy pregnancy.**Starting Point/Baseline:**

As of 2012, LPDS operates twelve women's centers.

Rationale:

Adult and aging women have specific healthcare needs that are best served by an integrated team trained and experienced in ongoing women's healthcare concerns. This project seeks to improve access and benefit from the successful model already in place at Las Palmas Del Sol Women's Centers.

Patients may experience barriers in accessing primary care services, including 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, and more appropriate utilization. This project will allow early interventions and early access to primary care resources in the community, and as a result of early and ongoing prenatal care, will decrease the percentage of low-weight births.

Project Components:

This project will accomplish the following project components:

a) Establish more primary care clinics.

- LPDS will establish four additional outpatient women's center under this project.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care

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

Currently, hours are only provided Monday through Friday with no weekend accessibility. Also, there has been an inconsistent attempt by LPDS to provide community awareness and patient education regarding women's services. This project represents an enhanced initiative relative to our current women's services at LPDS.

Related Category 3 Outcome Measures:

OD 8 – Perinatal Outcomes
IT 8.2 Percentage of Low Birth-weight births (CHIPRA/NQF #1382)
094109802.3.2

Reasons/rationale for selecting the outcome measures:

This project will reduce the percentage of low-weight births by offering outpatient women's services to those that cannot afford, or do not have access to a primary care physician. As a result of this intervention and partnership with primary care resources, these women will be able to access prenatal care much earlier in their pregnancy, which will result in better outcomes for the mother and baby. The goal of this project is to get women in the El Paso community the early interventions that can be so crucial in a healthy birth. This project will also increase community awareness of the healthcare services provided by the clinic and provide additional education to ensure the population is accessing the right care in the right setting.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, this project will complement LPDS's Primary Care Physician Recruitment project (094109802.1.1) and Psychiatric Telemedicine project (094109802.1.4);

each of these projects is intended to increase access to important health care services for patient populations with an identified need and an identified lack of timely access. Furthermore, this project will complement the Primary Care Physician Recruitment project in developing and expanding a robust community-wide network of primary care services in El Paso.

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

UMC El Paso, Tent Sierra Providence East Medical Center, and Providence Memorial Hospital have developed plans to implement projects that will also increase access to primary care at their facilities.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$6,923,143. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the cost savings that can result from the successful implementation of primary care programs such as this project, and the administrative complexity involved in establishing new outpatient clinics. The cost savings to the overall healthcare delivery system was also considered in the valuation of this project, as early intervention with prenatal care can prevent high-cost NICU stays and other complications.

094109802.1.2	*1.1.1*	*1.1.1*	*OUTPATIENT WOMEN'S IMAGING SERVICES EXPANSION*	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.2*	*IT 8.2*	***Percentage of Low-weight births (CHIPRA #1382)***	
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 or expanded hours or space Data Source: Documentation of detailed expansion plans Baseline/Goal: As of 2012, LPDS has 12 Outpatient Women's Centers, which see about 12,000 patients per year. Goal: Open 2 additional Centers in DY2. Milestone 1 Estimated Incentive Payment: $1,693,155	**Milestone 2** [P-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:Open 2 additional Centers in DY3. Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment: $923,571 **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: Increase number of patients seen at all Outpatient Women's Centers by 4,000 over DY2. Data Source: Registry, EHR, claims, or other Performing Provider source.		**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: Increase number of patients seen at all Outpatient Women's Centers by 8,000 over DY2. Data Source: Registry, EHR, claims, or other Performing Provider source. Milestone 4 Estimated Incentive Payment: $1,852,511	**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. Baseline/Goal: Increase number of patients seen at all Outpatient Women's Centers by 8,000 over DY2. Data Source: Registry, EHR, claims, or other Performing Provider source. Milestone 5 Estimated Incentive Payment: $1,530,335

094109802.1.2	***1.1.1***	***1.1.1***	***OUTPATIENT WOMEN'S IMAGING SERVICES EXPANSION***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.2*	*IT 8.2*	***Percentage of Low-weight births (CHIPRA #1382)***	
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 4 Estimated Incentive Payment: $923,570			
Year 2 Estimated Milestone Bundle Amount: $1,693,155	Year 3 Estimated Milestone Bundle Amount: $1,847,141		Year 4 Estimated Milestone Bundle Amount: $1,852,511	Year 5 Estimated Milestone Bundle Amount: $1,530,335
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,923,143				

95790

Project Option 1.3.1: Implement/enhance and use chronic disease management registry functionalities: **DEVELOP DIABETES MANAGEMENT REGISTRY**

Unique Project ID: 094109802.1.3

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will establish a Clinical Information System (registry) to structure, organize, and trend patient data for registries, performance measurements, and prevention services. This registry will help identify patients for inclusion and assist patients through the registry to track and manage their disease.

Need for the project: Diabetes disproportionately affects people with Hispanic origins and other minority populations. El Paso has a population that is approximately 80 percent Hispanic, as well as about 5% of other ethnicities, such as Asians, that are prone to diabetes. According to the El Paso Diabetes Association, more than 85,000 persons in El Paso are stricken with diabetes and as many as 25 percent of them don't know they have it. Type 2 diabetes affects 90 percent of all diabetics in El Paso. Early intervention and lifestyle changes can make a huge difference in managing patients with diabetes. These preventative measures can reduce the number of renal failure cases, which cost the healthcare about $7,680 per case, and many other complications that result from untreated or under-managed diabetes.

Target Population: The target population is the patient population that is suffering from diabetes and pre-diabetes. Based on 2012 data, we estimate that about 2,500 LPDS patients suffer from diabetes. About 44% of our facility-wide patient population is Medicaid eligible or indigent. We expect that this project will reflect a similar benefit to Medicaid eligible or indigent patients.

Category 1 or 2 Expected patient benefits: The project seeks to establish a registry for diabetic patients to more efficiently track and manage patients' medication and treatment. We do not anticipate that any patients will benefit in DY2 or DY3, as LPDS will analyze the type, scope, and company to implement the registry in DY2 prior to entering patients and realizing results, and operationalize the registry and train providers on using the registry to track and manage patients in DY3. We expect 500 people to be enrolled in the registry in DY4, and 1500 enrollees in DY5.

Category 3 outcomes: IT-3.3 Our goal is to reduce the diabetes 30-day readmission rate by 2.5% from DY3 to DY4, and 5% over DY3 in DY5.

Project Description:

HCA Las Palmas Del Sol will establish a chronic disease registry for patients with diabetes, so that their care can be tracked and managed within the local community.

A disease registry requires technology and adequate staffing to support it. Entering this data can be time intensive, but ultimately enhances patient care. To establish the diabetes patient registry, HCA Las Palmas Del Sol will identify patients for inclusion and assist patients through the registry to track and manage their disease. We also want to investigate the need to track and manage the large population with pre-diabetes. Currently it is unclear whether or not these patients can be tracked within the diabetes registry. The model will include a Clinical Information System (registry) to structure, organize, and trend patient data for registries, clinical outcomes, and prevention services. The registry we are considering is called CDEMS and is used by community health centers, primary care practices, rural clinics, hospitals, and quality improvement projects across the United States and in Canada, India, Haiti, and South Africa. This program was developed and is shared by the Washington Diabetes Prevention and Control Program.

Goals and Relationship to Regional Goals:

Project Goals: Diabetes registries will be fully implemented by DY 5; staff reference and maintenance of the registry will be part of the standard provision of care by DY 5. This registry can serve as a pilot project for the Health Information Exchange (HIE) initiative through the Paso Del Norte Health Foundation.

This project meets the following regional goals: This project is tied to the Regional 15's goal of providing better management of patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, Epilepsy, Dementia, and Renal disease to help prevent unnecessary readmission and get patients the care they need to prevent, self-manage, and address in an appropriate setting. LPDS will accomplish this goal by tracking and managing diabetic patients through a registry database system.

Challenges:

Challenges include: identifying all patients with diabetes and pre-diabetes; hiring staff and training them on use of the registry; maintaining an up-to-date registry on a consistent basis; use of same database registry across the community. There are some databases that could fit our needs, but further research on these databases needs to be conducted.

5-Year Expected Outcome for Provider and Patients:

By more effectively managing chronic disease patients discharged from our facility, we expect to reduce inappropriate ED utilization. This project will also reduce costs to the overall healthcare delivery system and provide more self-management education to patients with chronic diseases. Finally, we hope to increase the number of patients that are discharged to a community placement or organization.

Starting Point/Baseline:

Currently, there is not a hospital-wide registry of patients with diabetes.

Rationale:

Over 16 million Americans have diabetes. Type-2 diabetes is the most common form, accounting for 90 to 95 percent of cases. In El Paso, the weighted estimate of the prevalence of self-reported diabetes mellitus was 7.3 percent (95%CI=5.5%, 9.0%), or nearly 34,000 adult diabetics (1996

PDNHF BRFSS). We believe, based on results of the 1996 PDNHF Survey and estimates from other studies that the number of people 18 years and older in El Paso with glucose intolerance is actually closer to 94,000. Diabetes is the ninth leading cause of death in El Paso County and the death rate from diabetes in El Paso County is nearly 10 percent higher than the statewide average (Texas Department of Health/Texas Diabetes Council). Findings from the 1996 PDNHF BRFSS indicate that obesity, education, income, and access to healthcare are factors affecting El Paso County's high diabetes morbidity and mortality rates.

Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions, because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care.

Project Components:

This project will accomplish the following project components:

a) Enter patient data into unique chronic disease registry.
    - LPDS will enter patient data into the hospital-wide diabetes registry.

b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
    - LPDS will use data from the hospital-wide diabetes registry in order to better serve diabetes patients.

c) Use registry reports to develop and implement targeted QI plan.
    - LPDS will conduct quality improvement activities based in part on the data made available by the registry.

d) Conduct quality improvement for the project using methods such as rapid-cycle improvement.
    - LPDS will improve the registry by conducting quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-1: Secondary and Specialty Care

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

Currently, LPDS does not utilize a chronic disease database system that can be used to track diabetic patients. Utilization of a registry will help care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventative care.

<u>Related Category 3 Outcome Measures:</u>

OD-3 Potentially Preventable Readmissions—30-Day Readmission Rates
IT-3.3: Diabetes 30-day readmission rate
094109802.3.3

Reasons/rationale for selecting the outcome measures:

This project will improve patient satisfaction scores by expanding the hours of operation at the clinic and providing improved access to women's services. This project will also increase community awareness of the healthcare services provided by the clinic and provide additional education to ensure the population is accessing the right care in the right setting.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, this project will complement LPDS's Congestive Heart Failure Clinic project (094109802.2.2); both of these projects are targeted towards patient populations for whom delivery system reform could result in great improvements in the cost and quality of care, as well as improvements in overall patient population health.

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

UMC El Paso, Tent Sierra Providence East Medical Center, and Providence Memorial Hospital have developed plans to implement projects that will also improve readmission rates at their facilities.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$6,461,600. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the significant cost savings when diabetes patients are assisted to more effectively self-manage their care, as well as the logistical difficulties and costs that will need to be borne in order to

effectively coordinate the development of this project's infrastructure and the implementation of the project's procedures.

094109802.1.3	*1.3.1*	*1.3.1.A-D*	*DEVELOP DIABETES MANAGEMENT REGISTRY*
HCA Las Palmas Del Sol			*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.3*	*IT-3.3*	***Diabetes 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]: Review current registry capability and assess future needs. Metric 1 [P-2.1]: Documentation of review of current registry capability and assessment of future registry needs. Baseline/Goal: n/a Data Source: EHR systems; other performing provider documentation. Milestone 1 Estimated Incentive Payment: $790,139 **Milestone 2** [P-3]: Develop cross-functional team to evaluate registry program. Metric 1 [P-3.1]: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program. Baseline/Goal: n/a Data Source: Team roster and minutes from team meetings. Milestone 2 Estimated Incentive Payment: $790,139	**Milestone 3** [P-4]: Implement/expand a functional disease management registry. Metric 1: [P-4.1]: Registry functionality is available in 100% of the Performing Provider's sites and includes an expanded number of targeted diseases of clinical conditions. Baseline/Goal: Currently there is no diabetes management registry, we will implement the registry in 2 of 2 hospital facilities (Las Palmas and Del Sol). Data Source: Documentation of installation, upgrade, interface, or similar documentation, such as contract with management registry consultant/company. Milestone 3 Estimated Incentive Payment: $1,723,999	**Milestone 4** [I-15]: Increase the percentage of patients enrolled in the registry. Metric 1 [I-15.1]: Percentage of patients in the registry. Baseline/Goal: 20% of the target population (2,500 diabetes patients), about 500 patients enrolled in the registry. Data Source: Registry or EHR. Milestone 4 Estimated Incentive Payment: $1,729,010	**Milestone 5** [I-15]: Increase the percentage of patients enrolled in the registry. Metric 1 [I-15.1]: Percentage of patients in the registry. Baseline/Goal: 60% of the target population (2,500 diabetes patients), about 1500 patients enrolled in the registry. Data Source: Registry or EHR. Milestone 5 Estimated Incentive Payment: $1,428,313
Year 2 Estimated Milestone Bundle Amount: $1,580,278	Year 3 Estimated Milestone Bundle Amount: $1,723,999	Year 4 Estimated Milestone Bundle Amount: $1,729,010	Year 5 Estimated Milestone Bundle Amount: $1,428,313
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,461,600			

95793

Project Option 1.7.1: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: **PSYCHIATRIC TELEMEDICINE**

Unique Project ID: 094109802.1.4

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will seek to establish tele-psychiatric consultation in the emergency department to provide immediate access to psychiatric consultative services, provide needed guidance to emergency department physicians, and facilitate the management of psychiatric patients through the emergency department.

Need for the project: The ED currently utilizes on-site consultative services that can take up to two days in the ED, which delays appropriate care of psychiatric patients and ties up ED resources unnecessarily. Once a patient has been admitted, it can take up to 2 weeks to receive an inpatient consultation, which costs the healthcare system about $24,500 and occupies a bed that could otherwise be used by a patient with emergent condition. Tele-psychiatric consultation can speed up the process and provide better care for the patient by potentially having a tele-consult within an hour of requesting one.

Target Population: The target population is the psychiatric patients seen in our emergency departments. We see between 1,500 to 1,800 psychiatric patients in our ED per year for the Las Palmas Del Sol Healthcare System. About 64% of our ED patient population is Medicaid eligible or indigent. We expect that this project will have a greater percentage of Medicaid-eligible or indigent patients, as the patients that generally present for psychiatric services at the ED are low-income or indigent persons in the community that do not have access to alternate psychiatric care.

Category 1 or 2 Expected patient benefits: We do not expect that any patients will be served directly by this project in DY2, as LPDS will be conducting a needs assessment and preparing for implementation early in DY3. In DY3, we expect to have use telemedicine consultations for about 20% of psychiatric patients presenting in the ED, which is about 300 patients, provide the services to 45% of the psychiatric patients presenting in the ED, which is about 675 patients in DY4, and provide service to 60% of the target population in DY5, which is about 900 patients.

Category 3 outcomes: IT-2.4 Our goal is to improve the behavioral health/substance abuse (BH/SA) admission rate by 2.5% from DY3 to DY4, and 2.5% from DY4 to DY5.

Project Description:

This plan would expand coverage through the use of a contracted vendor to provide for the evaluation of acute behavioral health patients in the Emergency Departments.

This plan would expand coverage through the use of a contracted vendor to provide for the evaluation of acute behavioral health patients in the Emergency Departments. Currently, the process of obtaining a consult can take up to two weeks or more, during which time the patient is in the Emergency Department the entire time. A tele-psychiatric consultation could potentially have a turn-around disposition time of about an hour. The availability of psychiatric consultation in the Emergency Department through the tele-psychiatry model would provide immediate access to psychiatric services currently not available to the patient, provide needed guidance to the Emergency Department physicians, and facilitate the management of psychiatric patients through the ED. We believe this would enhance the quality and appropriateness of patient care, lead to earlier and more appropriate pharmacologic interventions that will expedite the stabilization and disposition of patients. To validate the effectiveness of the program, we will design and conduct process improvement activities for this tele-psychiatry program once it has been implemented to promote higher quality and efficiency standards. Validation processes will include reduction of psychiatric hold hours in the Emergency Departments, improve clinical outcomes, and increase patient satisfaction and safety.

Goals and Relationship to Regional Goals:

Project Goals: Establish telemedicine capability in the Emergency Departments to include 24/7 availability of tele-psychiatry to provide for the evaluation of the acute behavioral health patient and provide guidance and support to the Emergency Department physicians. Improve the quality and appropriateness of care provided to behavioral health patients through earlier and more accurate diagnosis. The availability of tele-psychiatry should lead to earlier implementation of the most appropriate therapy. Earlier and more appropriate psychiatric intervention may result in some behavioral health patients being stabilized in the Emergency Department and not requiring transfer for inpatient psychiatric services.

This project meets the following regional goals: This project is tied to Region 15's goal of better management of patients with chronic conditions, preventing unnecessary admissions and ensuring patients are accessing the right care in the right setting. This project will ensure that timely consults will enable the patient the right kind of care in the appropriate setting, either in a psychiatric facility or medical management in the emergency room and then clinical discharge.

Challenges:

Analyzing impact and benefit from implementing a telemedicine program to address psychiatric needs in El Paso; training physicians and staff on new telemedicine equipment; software and connectivity issues; accurately measuring the change in service availability and patient satisfaction; patient and family perception of psychiatric healthcare delivery via this modality; collaboration of care between the tele-psychiatric professionals and the local psychiatric hospitals.

5-Year Expected Outcome for Provider and Patients:

The expected outcome of reducing the time of the initial referral (consult) will be realized upon implementation of tele-psychiatric consultation. Currently, it takes anywhere from 10 hours to 2 days to receive a psych consult. In the meantime, these patients are NOT admitted but remain in the emergency room taking up a bed and quite possibly a threat to other emergency room

patients. Knowing the proper course of treatment for these patients via tele-psych consults will enable a better flow of patients and a better patient experience for everyone, not to mention the right care in the right setting for the psychiatric patient.

Starting Point/Baseline:

Neither facility has inpatient psychiatric beds or services, neither facility is licensed as a psychiatric facility, and neither facility has psychiatric consultation available in its Emergency Department (ED).

Rationale:

Behavioral health consumers frequently wait hours or even days in crowded ED's before receiving psychiatric evaluation and placement. Hospital reports show that patients with behavioral health concerns typically stay longer and yield less reimbursement than medical patients.

One of the greatest challenges facing the U.S. healthcare system is to provide quality care to the large segment of the population which 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.

The use of telecommunications technologies and connectivity has impacted real-world patients, particularly for those in remote communities, especially communities such as El Paso. This work has translated into observable outcomes such as:

- improved access to specialists;
- increased patient satisfaction with care;
- improved clinical outcomes;
- reduction in emergency room utilization;
- cost savings.

Nowhere are these benefits more evident than in Texas. With a land mass area of 268,820 square miles and a growing population of 25.1 million, Texas is the second largest U.S. 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. 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 immigration from other states and countries. Along with the increase in population, an ever-growing aging population has significantly affected the demand on the healthcare workforce as demands for quality care increased.

Project Components:

This project will accomplish the following project components:

a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications.

- LPDS will provide consultations by behavioral health specialists using telecommunications.

b) Conduct quality improvement for the project using methods such as rapid-cycle improvement.

- LPDS will improve its telemedicine capabilities by conducting quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care

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

This project represents an enhanced initiative to the system already in place at LPDS. Currently, a psychiatric doctor will physically present at the emergency room to provide a consultation. While LPDS is still providing the means to a psychiatric consult, the timeliness presents issues when trying to implement effective healthcare. Also, LPDS does not currently have psychiatric beds. While there is no intent to increase the number of psychiatric beds at LPDS, we are still committed to providing the right kind of care in the right setting.

Related Category 3 Outcome Measures:

OD-2 Potentially Preventable Admissions

IT-2.4: Behavioral Health/Substance Abuse (BH/SA) Admission Rate

094109802.3.4

Reasons/rationale for selecting the outcome measures:

This project will reduce the amount time it takes to get a psychiatric consult and should also reduce unnecessary admissions due to the lack of a consultation. By implementing a tele-psychiatric consultation service and leveraging health information technologies already being utilizing by other specialties (i.e. neurology), LPDS will be better positioned to care for and appropriately manage the patient flow of psychiatric patients through the emergency room.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, this project will complement LPDS's Physician and Mid-Level Recruiting and Training project (094109802.1.4) and Outpatient Women's Imaging Services Expansion project (094109802.1.2); each of these projects is intended to increase access to important health care services for patient populations with an identified need and an identified lack of timely access. Furthermore, this project will complement LPDS's Electronic Medical Records project (094109802.2.1) to the extent that both projects will strengthen the technological infrastructure in use at LPDS, and will maximize the benefits of that technology from the standpoint of cost, quality of care, and access to care.

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

UMC El Paso has developed plans to implement a project that will also improve services for El Paso residents suffering from behavioral health issues.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$8,307,772. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the costs that will be incurred to develop the technological infrastructure necessary to the project's implementation, and the current severe lack of access to appropriate psychiatric care for patients presenting at the emergency department.

094109802.1.4	***1.7.1***	***1.7.1(A-B)***	***PSYCHIATRIC TELEMEDICINE***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.4*	*IT-2.4*	***Behavioral Health/Substance Abuse (BH/SA) 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-2] Conduct needs assessment to identify needed services that can be provided via telemedicine. Metric 1: [P-2.1]: Needs assessment Baseline/Goal: Currently, LPDS does limited telemedicine in the neurology department. We will submit 1 needs assessment that determines psych services that are most needed at the facility and determines how to address those through a new telemedicine system in the ED and/or inpatient units, as appropriate. Data Source: Needs Assessment Milestone 1: Estimated Incentive Payment: $2,031,786	**Milestone 2** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. <u>Metric 1</u> [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation. Baseline/Goal: Provide services to 20% of all BH/SA patients in ED, which will be 300 patients. Data Source: Log of tele-services by type of health care professionals and type of service. Milestone 2: Estimated Incentive Payment: $2,216,570		**Milestone 4** [I-12.1]: Increase number of telemedicine visits for each specialty identified as high need. <u>Metric 4</u> [I-12.1]: Number of tele-medicine visits. Baseline/Goal: Provide services to 45% of BA/SA patients in the ED, which will 675 patients. Data Source: EHR encounter records from tele-medicine program Milestone 4 Estimated Incentive Payment: $2,223,013	**Milestone 4** [I-12.1]: Increase number of telemedicine visits for each specialty identified as high need. <u>Metric 4</u> [I-12.1]: Number of tele-medicine visits. Baseline/Goal: Provide services to 60% of BA/SA patients in the ED, which will 900 patients. Data Source: EHR encounter records from tele-medicine program Milestone 4 Estimated Incentive Payment: $1,836,402
Year 2 Estimated Milestone Bundle Amount: $2,031,786	Year 3 Estimated Milestone Bundle Amount: $2,216,570		Year 4 Estimated Milestone Bundle Amount: $2,223,013	Year 5 Estimated Milestone Bundle Amount: $1,836,402
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,307,772				

95779

PROJECT REPLACEMENT
(For deleted project 094109802.2.2)

Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology, and processes to avoid medication errors—Implement Computerized Physician Order Entry (CPOE): **ELECTRONIC MEDICAL RECORDS REPLACED** with:

Project Option 1.9.1: Expand high impact specialty care capacity in most impacted medical specialties: **EXPAND SPECIALTY CARE CAPACITY –** BELOW.

Unique Project ID: 094109802.1.5

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Project Summary:

Provider: Las Palmas Del Sol (LPDS) is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000. HHSC has also designated LPDS as a Major Safety Net Hospital in Region 15.

Intervention(s): In DY2, LPDS will perform and implement a community needs assessment to determine specialties that are underserved at LPDS. In DY3, LPDS will initiate recruitment of two specialists and staff as needed and formation or expansion of two specialty clinics in DY3 to better meet the needs of the El Paso community. LPDS will begin expanding specialty provider clinic hours in DY4 to increase the availability of specialist services. This project will not directly serve patients in DY2 and DY3, as the project will focus in these years on recruiting and retaining two specialists, while also establishing or expanding two additional clinics; the purpose of these actions is to lay the groundwork for direct patient benefit in future program years and beyond. LPDS expects about 1,300 additional patient visits in DY4 as a result of the recruiting and retention of the two additional providers. LPDS expects about 1,560 additional patient visits in DY5 due to the increase in specialist provider hours.

Need for the project: El Paso County and the surrounding geographic region presently suffers from a severe shortage of specialty care providers. A recent assessment revealed a shortfall of 100 specialty providers relative to the demand associated with the region's population levels. This shortage, together with the shortage of primary care in the area, represents a severe lack of access to health care in the greater El Paso region. In turn, this lack of access to care has an untoward effect on the overall wellbeing of the population.

Based on internal reports from 2011 data, LPDS has identified shortages in many physician specialties, with the largest deficits being in Cardiology, General Surgery, Neurology and GI. LPDS will more specifically quantify these shortages by conducting a detailed gap analysis in

DY2. Based on the findings that result from this gap analysis, LPDS will identify and pursue two specialists (and support staff) for underserved specialty service areas.

Target population: LPDS serves the El Paso metropolitan area, which is home to a population of about 820,000. About 44% of LPDS's facility-wide patient population is Medicaid-eligible or indigent. LPDS expects that this project will benefit a similar proportion of Medicaid-eligible or indigent patients. LPDS expects that recruiting two additional providers in DY2 and establishing or expanding two specialty clinics in DY3 will increase patient visits by about 1,344 visits by DY5.

Category 1 or 2 expected patient benefits: Based on the gap analysis conducted in DY2, LPDS will identify and pursue a specialist and support staff for two needed specialty service areas. This project will add two specialist providers, while also establishing two new clinics or expand existing specialty clinics (depending on the providers recruited), which will increase provider hours in the specialty by about 1,300 hours in DY4, and 1,560 hours in DY5. This increase in specialist provider hours will allow more patients to access specialty services which are currently suffering from shortages in the El Paso community.

Category 3 outcomes: LPDS believes that patients will have better access to specialty care as a result of this project's expansion of specialty care services, which will result in an improvement in patient satisfaction scores for the target population of the project.

Project Description:

In DY2, LPDS will perform and implement a community needs assessment to determine specialties that are underserved at LPDS. In DY3, LPDS will recruit two specialists and staff as needed, and form or expand two specialty clinics to better meet the needs of the El Paso community. In DY4, LPDS will increase the availability of specialist services by expanding hours at these specialty provider clinics.

The ultimate goal of this project is to support population health and the overall wellbeing of the population of the El Paso community; this goal will be achieved by increasing the number of specialty providers and specialty services. LPDS will ensure that the project has the desired effect by basing its DY3 and DY4 steps on community needs first identified in DY2. As noted in the region's community needs assessment, there is a severe shortage of specialty care in the El Paso region. Because of this shortage, patients, including large numbers Medicaid-eligible and uninsured patients, are often forced to seek out-of-area care to meet their needs. Medicaid-eligible and uninsured patients are often the least able of any population to successfully obtain the out-of-area care they may need, and thus these populations often suffer the most from shortages in specialty care and will benefit the most from this project. LPDS recognizes that it will be challenging to recruit and retain two additional specialists and to increase access to care by extending clinic hours, but LPDS is confident that the gap analysis (to be conducted in DY2) and the other steps outlined in this project narrative will enable LPDS to successfully accomplish the goals of this project and to support the goals of the Waiver.

Goals and Relationship to Regional Goals:

Project Goals: LPDS's goal in implementing this project will be to open or expand at least two specialty clinics, based on a community needs assessment to be conducted in DY2. LPDS will also use this assessment to plan its recruiting of two additional specialty physicians in DY3.

This project meets the following regional goals: RHP 15 has identified a variety of goals for the region, including the goals of increasing the number of specialists and the scope of specialty services offered in the community. Utilizing a community assessment to identify the community need for specialist services and target recruitment efforts, will specifically align to this regional goal. The expected outcome of the project will also support the region's identified goal of improving the patient experience through delivery of high-quality, effective healthcare services.

Challenges:

The major challenge associated with this project will be the recruitment and retention of the specialty physicians. LPDS plans to overcome this by offering potential recruits income guarantees for a year or employment via 501a entity. There are a variety of incentives to help the physician flourish including, sign on bonus, relocation assistance, malpractice tail coverage and tuition (stipend) assistance. LPDS also believes that physicians will be more satisfied with their own work when patients are satisfied and when patients are receiving high-quality care that is essential to their well-being. Therefore, LPDS believes that the successful implementation of quality-improvement activities will address this challenge by improving the quality of care that is delivered and thereby making it more likely that physicians will choose to continue providing care in the El Paso region.

5-Year Expected Outcome for Provider and Patients:

LPDS expects that the establishment of a specialty clinic, based on the demand of these targeted services, will increase specialty care access to meet currently unmet needs for those services in the El Paso community. LPDS also expects that the population's overall health and well-being of will be improved as a result of increasing the number of specialty providers and specialty services based on the community's identified needs. More broadly, LPDS expects that its implementation of quality improvement activities related to clinic operations, patient experience, and overall outcomes will ensure the delivery of quality healthcare to the region.

Starting Point/Baseline:

The deficit of physician specialists in the primary service area of LPDS is in excess of 98 providers, based on 2011 data. Based on the community needs assessment that will be conducted in DY2, LPDS will establish or expand specialty clinics within the community. LPDS will also recruit two specialists and support staff, as necessary, to provide services identified as needed by the community needs assessment. Together, LPDS expects that these steps will increase the provider hours in the targeted specialty or specialties by about 1,300 hours in DY4, and 1,560 hours in DY5.

Rationale:

El Paso County and the surrounding geographic region presently suffers from a severe shortage of specialty care providers. A recent assessment revealed a shortfall of 100 specialty providers relative to the demand associated with the region's population levels. This shortage, together with the shortage of primary care in the area, represents a severe lack of access to health care in

the greater El Paso region. In turn, this lack of access to care has an untoward effect on the overall wellbeing of the population. This lack of access must be addressed; however, rather than making assumptions that are not backed by research and analysis, LPDS believes it is essential to perform an evidence-based gap analysis regarding health disparities in the region and the particular need for specialists in specific practice areas and geographic areas. LPDS will use the results of this analysis to determine which specialty or specialties to target in the next steps of the project in later years.

Project Components:

This project will accomplish the following project components:

e) Identify high impact/most impacted specialty services and gaps in care and coordination
   - In DY2, LPDS will conduct a gap analysis to identify specialty areas impacted by shortages and subject to gaps in care and coordination in the El Paso community.

f) Increase the number of residents/trainees choosing targeted shortage specialties.
   - In DY3, LPDS will identify, recruit, and retain two specialists in one or more of the specialty areas identified by the DY2 gap analysis. LPDS will also conduct an analysis to determine the extent to which support staff and personnel will be necessary.

g) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)
   - As part of the recruitment efforts in DY2, LPDS will establish a committee to develop unique recruitment strategies and analyze ways that the facility can improve retention efforts for current team members.

h) 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.
   - Throughout each year of the project, LPDS will continue to participate in RHP meetings held by the Anchor, and will conduct quarterly internal meetings intended to ensure that this project is implemented and successfully integrated into the overall facility healthcare delivery framework.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care

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

LPDS has been committed to increasing access to primary and specialty care, which is evidenced by its history of recruitment efforts. LPDS intends to enhance this ongoing initiative by conducting a detailed, evidence-based community gap analysis in DY2. LPDS will also enhance its recruitment initiatives through a renewed commitment to implement and maintain quality improvement activities related to clinic operations, patient experience, and overall quality outcomes, creating an environment in which specialty physicians are providing high-quality care to satisfied patients.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction
IT-6.1: Percent improvement over baseline of patient satisfaction scores
094109802.3.6

Reasons/rationale for selecting the outcome measures:

As this project is implemented and two new specialists are recruited and retained to fill needed areas of specialty care at the facility, LPDS believes that patients will have better access to specialty care. This improved access will result in a corresponding improvement in patient satisfaction scores for the project's target population. Specifically, LPDS expects that the successful implementation of this project will be accompanied by an improvement in patients' rating of their access to specialty care in the target population—i.e., those patients that receive the new or expanded specialty services or utilize the new or expanded specialty clinics.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement LPDS's Primary Care Physician Recruitment (094109802.1.1) in developing and expanding a robust community-wide network of primary care and specialty care services in El Paso.

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

This project is congruent with similar Expand Specialty Care Capacity projects to be performed in RHP Region 15 by Sierra Providence East Medical Center and Providence Memorial Hospital. LPDS, Sierra East, and Providence expect that the similar structure of these projects will foster effective collaboration and sharing of lessons learned between the three providers as the implementation process for these valuable projects moves forward.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and

minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$7,384,686. In determining the value of this project, LPDS considered the extent to which increased access to specialty care will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). In order to guarantee that the project's implementation will in fact have a valuable impact on the needs of the El Paso community, LPDS has chosen to base the steps of the project in DY3 and DY4 on an assessment of community needs, to be conducted in DY2. LPDS believes that the expense and difficulty of recruiting and retaining physicians—particularly specialty physicians—in an underserved community such as El Paso is a major factor justifying the valuation that has been placed on this project.

*094109802.**1.5***	***1.9.1***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.6*	*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]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period. Baseline/Goal: Completed needs assessment. Data Source: Needs assessment. Patient Impact: 0 specialty patient visits Milestone 1 Estimated Incentive Payment: $1,806,032	**Milestone 2** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of specialist providers by 2 based on the DY2 gap analysis Data Source: HR documents or other documentation demonstrating employed/contracted specialists. Patient Impact: 0 specialty patient visits Milestone 2 Estimated Incentive Payment: $985,142 **Milestone 3** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish/expand specialty care clinics. Baseline/Goal: Establish or expand at least 2 new clinics. Data Source: Documentation of new/expanded specialty care clinic. Patient Impact: 0 specialty patient visits		**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of clinic hours at the facility by 1,300 hours. Data Source: Clinic Schedules demonstrating increased hours of availability. Patient Impact: 1,300 additional specialty patient visits Milestone 4 Estimated Incentive Payment: $1,976,012	**Milestone 5** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of clinic hours at the facility by 1,560 hours. Data Source: Clinic Schedules demonstrating increased hours of availability. Patient Impact: 1,560 additional specialty patient visits Milestone 5 Estimated Incentive Payment: : $1,632,358

*094109802.**1.5***	***1.9.1***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.6*	*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 3 Estimated Incentive Payment: $985,142			
Year 2 Estimated Milestone Bundle Amount: $1,806,032	Year 3 Estimated Milestone Bundle Amount: $1,970,284		Year 4 Estimated Milestone Bundle Amount: $1,976,012	Year 5 Estimated Milestone Bundle Amount: $1,632,358
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,384,686				

Project Option 1.1.2: Expand existing primary care capacity: **EXPAND PRIMARY CARE ACCESS**

Unique Project ID: 130601104.1.1

Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 196829901

Provider: Providence Memorial Hospital is a 508 bed, acute care facility in El Paso Texas. PMH provides pediatric services to the community and serves the community of El Paso, which has a population of about 665,000. HHSC has also designated Providence as a Major Safety Net Hospital in Region 15.

Intervention(s): This project will establish one Urgent Care Center in DY2, expanding the hours and hiring personnel to staff expanded hours at Providence's 2 existing clinics (Clinic #1 and Clinic #2) in DY3. to ensure the Medicaid and uninsured patient population have access to the appropriate venue for care.

Need for the project: El Paso has a severe shortfall of available primary care physicians and facilities available to support primary care for prevention and chronic care management. Currently the facilities' Emergency Department (ED) is being utilized for primary care as evidenced by 30% of non-urgent visits.

Target population: The target population for this project are our patients that currently use the ED for non-urgent conditions. Approximately 14% of the ED patients are uninsured and approximately 40% of the ED patients are insured by Medicaid or Medicaid Managed Care. We expect that a similar percentage of Medicaid eligible and uninsured patients will benefit from the implementation of this project.

Category 1 or 2 expected patient benefits: Increasing primary care access through the establishment of an Urgent Care facility with an increase in hours of availability based on the needs of the population will provide the patients with a more effective and efficient primary care alternative. We do not expect any patients to benefit directly from this project in DY2, as Providence will be establishing a new Urgent Care Center (Clinic #3). We expect about 3,750 additional patients visits will occur in DY3, 4,480 in DY4, and 4,772 in DY5 as a result of the establishment of this new Urgent Care Center and the expanded hours of Providence's 2 existing Urgent Care Centers Clinic #1 and Clinic #2.

Category 3 outcomes: Establishing of Urgent Care clinic locations will make it more convenient for patients to choose primary care over emergent care, thereby making it more likely that they will do so, increasing patient satisfaction, and improving the quality of the patient experience while reducing the overall cost of care.

Project Description:

This project will establish one Urgent Care Center in DY2 and expand hours at the 2 existing Providence Urgent Care Clinics and hire personnel to staff those clinics in DY3 to ensure the Medicaid and uninsured patient population have access to the appropriate venue for care.

Increased access to primary care will help address a substantial need in the community for increased access to primary care. Additionally, seeing patients in an ambulatory setting will promote the appropriate level of care in the appropriate setting and reduces unnecessary ED admissions for conditions better served in a clinic setting.

Target Zip Codes: 79912, 79924

Goals and Relationship to Regional Goals:

Project Goals: A primary goal of this project is increasing access to primary care for the population served, promoting the appropriate level of care in the appropriate setting and reducing unnecessary ED admissions for conditions better served in a clinic setting, thus containing costs and healthcare infrastructure. The project will also promote the appropriate redirection of patients to Urgent Care locations, resulting in promoting better health outcomes, improvement of patient experience and reduced cost of services provided. The project will also involve education of the public specific to understanding "emergent versus urgent" conditions.

This project meets the following regional goals: Expanding hours of coverage, locations, and staffing of Urgent Care Centers to ensure the Medicaid and uninsured patient population has access to the appropriate venue for care, aligns to the goals of the Region, by increasing access to primary care. Additionally, seeing patients in an ambulatory setting will promote the appropriate level of care in the appropriate setting which aligns itself to a Regional goal as well. This project also allows us, during the redirection of patients from the ED, to provide patient education to ensure the population is accessing the right care in the right setting and promotes a better patient experience through delivery of high-quality, effective healthcare services, which aligns to the goals of our Region.

Challenges:

A major challenge facing the project is the high volume of uninsured and unfunded patients utilizing the Emergency Room. This project seeks to redirect non-emergent patients to Urgent Care Centers, which provides a more appropriate level of care. This will also reduce wait times and improve outcomes for those patients that have injuries or a condition that requires emergency attention because the non-emergent patients will have greater access to services other than the emergency room.

5-Year Expected Outcome for Provider and Patients:

This project will establish one new Urgent Care Center in DY2, expanding hours at the two existing Urgent Care Centers and hiring/training the professional staff for each clinic (Clinic #1 and Clinic #2) in DY3, and an increase in availability through expanded hours in DY4. Research shows that a strong primary care system can improve health outcomes and reduce health care costs. Primary care can also reduce costs by increasing access to preventive care. PMH believes the severe shortfall of available primary care physicians and facilities available to support primary care for prevention and chronic care management in the El Paso region, could affect why the El Paso region does not have health outcomes that correspond to our overall investment in healthcare. Thus, PMH believes that strengthening and growing our primary care workforce is critical to reforming the regions' health care system. PMH believes that increasing access to

primary care physicians and nurses can help prevent disease and illness and ensure our El Paso Region have access to high quality care.

Starting Point/Baseline:

Analysis of Emergency Department visits, classified as non-urgent and urgent, will provide the target population and medical conditions to develop protocols and education to redirect patients to the appropriate setting. Patient populations with multiple visits to the emergency department for urgent and non-urgent conditions will be evaluated to determine deterrents to primary care access.

Rationale:

It is well known the national supply of primary care does not meet the demand for primary care services. Moreover, it is a key goal of health care improvement to provide more preventative and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. Over 30% of Emergency Room visits are visits that could be seen in an Urgent Care setting. At present, many of the ED visits present in late afternoon and evening hours, when primary care offices are closing. Expansion of Urgent Care clinic hours will make it possible for those patients to be redirected to a more efficient and effective site of care, rather than giving them no choice but to present at an ED for costlier treatment with which patients may be less satisfied. Expansion of Urgent Care clinic staffing will make it possible to expand the clinics' hours. Expansion of Urgent Care clinic locations will make it more convenient for patients to choose primary care over emergent care, thereby making it more likely that they will do so, increasing patient satisfaction, and improving the quality of the patient experience while reducing the overall cost of care.

Project Components:

This project will accomplish the following project components:

a) Expand primary care clinic space in DY2.
    - Providence will establish one new Urgent Care Center (Clinic #3).

b) Expand primary care clinic hours at the 2 existing Urgent Care Centers (Clinic #1 and Clinic #2) in DY3.
    - Providence will expand its primary care hours of coverage.

c) Expand primary care clinic staffing.
    - Providence will expand its primary clinic staffing at the 2 existing Urgent Care Centers (Clinic #1 and Clinic #2) in DY3.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care

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

Expanding hours of coverage, locations, and staffing of Urgent Care Centers to ensure the Medicaid and uninsured patient population has access to the appropriate venue for care will be an ENHANCED initiative for PMH.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT-6.1: Percent improvement over baseline of patient satisfaction scores

130601104.3.1

Reasons/rationale for selecting the outcome measures:

As this project is implemented and Urgent Care Centers are made more available and accessible to the patient population, Providence believes that patients will have better access to primary care, which will result in an improvement in patient satisfaction scores for the target population of the project. Specifically, Providence expects that the successful implementation of this project will be evidenced by an improvement in patients' ratings of access to care in the target population.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Tenet's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2) and Implement/Expand Care Transitions project (130601104.2.1); each of these projects is intended to improve the patient experience by providing care in more effective and efficient ways. Furthermore, this project will complement Tenet's Expand Specialty Care Capacity project (130601104.1.3) in developing and expanding a robust community-wide network of primary care and specialty care services in El Paso.

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

This project is congruent with an Expand Primary Care Access project to be performed in RHP Region 15 by Sierra Providence East Medical Center (196829901.1.1).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and

minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$8,396,338. In determining the value of this project, Tenet considered the extent to which increased access to primary care through expanding its primary care clinics will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Tenet considered the significant cost savings that will result from the successful implementation of this project when patients are navigated away from high-cost treatment sites such as Emergency Rooms, as well as the significant investment that will be necessary to implement the project.

Tenet plans to implement a similar Category 1 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.1.1	***1.1.2***	***1.1.2. A-C***	***EXPAND PRIMARY CARE ACCESS***	
Providence Memorial Hospital				*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.1*	*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 clinics. <u>Metric 1</u> [P-1.1]: Number of additional clinics or expanded hours or space. Baseline/Goal: Establish 1 primary clinic (Clinic #3) Data Source: New primary care schedule Milestone 1 Estimated Incentive Payment: $2,053,447	**Milestone 2** [P-1]: Establish additional/expand existing/relocate primary care clinics. <u>Metric 1</u> [P-1.1]: Number of additional clinics or expanded hours or space. Baseline/Goal: Expand hours at the 2 pre-Waiver Clinics (Clinic #1 and Clinic #2) by 15 hours per week at each location. Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment: $746,734 **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: Increase of 3,750 patient visits over DY2 baseline. Data Source: Registry, EHR, or claims at UCC. Milestone 3 Estimated Incentive Payment: $746,733		**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 number of visits. Demonstrate improvement over prior reporting period. Baseline /Goal: Increase of 4,480 patient visits over DY2 baseline (new Clinic #3 plus expanded capacity at Clinic #1 and Clinic #2). Data Source: Registry, EHR, or claims at UCC. Milestone 6 Estimated Incentive Payment: $1,123,356	**Milestone 7** [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: Increase of 4,772 patient visits over DY2 baseline (new Clinic #3 plus expanded capacity at Clinic #1 and Clinic #2). Data Source: Registry, EHR, or claims at UCC. Milestone 7 Estimated Incentive Payment: $1,855,980

130601104.1.1	***1.1.2***	***1.1.2. A-C***	***EXPAND PRIMARY CARE ACCESS***	
Providence Memorial Hospital				*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.1*	*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 4 [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. Baseline/Goal: Addition of at least 2 primary care providers - 1 at each clinic (Clinic #1 and Clinic #2). Data Source: HR documentation of staffing at UCCs. Milestone 4 Estimated Incentive Payment: $746,733			
Year 2 Estimated Milestone Bundle Amount: $2,053,447	Year 3 Estimated Milestone Bundle Amount: $2,240,200		Year 4 Estimated Milestone Bundle Amount: $2,246,712	Year 5 Estimated Milestone Bundle Amount: $1,855,980
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,396,338				

93841

Project Option 1.4.4: Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels; the curricula should increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors; address the impact of race, ethnicity, culture, and class on clinical decision making; develop tools to assess the community members' health beliefs and behaviors; develop human resource skills for cross-cultural assessment, communication, and negotiation: **ENHANCE INTERPRETATION SERVICES AND CULTURALLY COMPETENT CARE**

Unique Project ID: 130601104.1.2
Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 130601104
Project Summary:
Provider: Providence Memorial Hospital is a 508 bed, acute care facility in El Paso Texas. PMH provides pediatric services to the community and serves the community of El Paso, which has a population of about 665,000. HHSC has also designated Providence as a Major Safety Net Hospital in Region 15.
Intervention(s): This project will involve the design and development of a program to improve the cultural competency of PMH staff as well as staff competency in assessment of health literacy**.** This program will develop a cross-cultural training curriculum that will:

- offer a cross-cultural training program that is an integrated component of the training and professional development of all clinical staff;
- increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors;
- increase awareness of the impact of race, ethnicity, culture, and class on clinical decision making, and
- develop the clinical staff skills for cross-cultural assessment, communication, and negotiation.

Need for the project: Currently there is not a formal program regarding the concept of cultural competent care or health literacy. This results in the lack of knowledge regarding health literacy, and the assumption that the staff is culturally competency due to Hispanic staff caring for Hispanic population. A diverse staff does not necessarily equal cultural competence. Cultural competency is defined as the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural and linguistic needs. Some gaps at the organizational level in the identified hospital are as follows

- no certified or trained interpreters,
- no evidence of policies specific to different cultures,
- lack of policy flexibility to make allowances for the needs of different cultures (e.g. visitation, environmental consideration),
- no training for direct patient care providers on identifying health literacy, and
- minimal culturally diverse patient and cafeteria meal selections.

Target population: The target population is all admitted inpatients of PMH, and will focus on those patients needing enhanced cultural and language attention from our staff. Our goal is to ensure that each patient receives high-quality care regardless of background or language barriers.

Approximately 40% of patient seen facility-wide are Medicaid eligible or indigent patients. Based on the correlation between poverty and minority populations in El Paso, it is likely that this project will affect a higher percentage of Medicaid eligible and indigent patents that our facility-wide average.

Category 1 or 2 expected patient benefits: Based on the needs identified in an organizational needs analysis, as well as a community gap analysis, Providence will design a program to improve cultural competence will be developed and implemented. In addition, the concept of Health Literacy along with tools and techniques will be introduced. With clear communication, Providence expects to contribute to the patient's understanding of their disease process, self-management concepts and what resources are available to them throughout their transition. We do not expect any direct patient impact in DY2, as Providence will be conducting gap analysis to determine areas for improvement in culturally competent care and developing a training program to enhance the organization's cultural competence. We expect that the 150 trained champions will be able to accomplish about 18,616 patient interactions in DY3, 20,448 in DY4, and 23,270 in DY5.

Category 3 outcomes: Enhancement of culturally competent care will promote care that is patient centered. This will result in an overall improvement of the patient experience as evidenced by an improvement in patients' ratings of the communication skills of their health care providers.

Project Description:

This project will improve effective communication by designing and developing a program to improve the cultural competency of Providence staff as well as staff competency in assessment of health literacy.

This goal of this project will be to design and develop a program to improve the cultural competency of the staff as well as competency in assessment of health literacy for the improvement of effective communication. Tenet believes that effective health communication is as important to health care as clinical skill. Tenet is committed to improving individual health and building healthy communities, and Tenet wishes to support our health care providers as they recognize and address the unique culture and health literacy of our diverse patient population. When this support is provided, patients will have access to qualified health care in their primary language and will support the likelihood of safe and effective care, open communication, adherence to treatment protocols, and better health outcomes. This project will involve the implementation of organizational performance improvement and transformational activities that spread learning and awareness, thereby building patient/provider communications that are culturally competent and health-literacy aware.

Goals and Relationship to Regional Goals:

Project Goals: A major goal of the project will be the improvement of patient experience as evidenced by improvement of Nurse/Physician communication scores and overall program scores on patient assessment tools.

This project meets the following regional goals: There is consensus about the nature and importance of cultural competence as an essential component of accessible, responsive, and high quality health care. Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes. This project will align to the Regional goals of improvement of the management patients with chronic diseases, to help prevent unnecessary readmission and

providing patients the care they need to prevent disease and to self-manage their disease process. The intent of the this project will support the Regional goals of overcoming language barriers to accessing healthcare resources in the region and increase the patient experience through delivery of high-quality, effective healthcare services.

Challenges:

Challenges facing the project include the current lack of knowledge regarding health literacy, and the assumption of culturally competency of staff due to Hispanic staff caring for Hispanic population. Challenges will be met by identifying the goal or desired change and the development of a cross-cultural training curriculum that will:

- offer a cross-cultural training program that is an integrated component of the training and professional development of all clinical staff;
- increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors;
- increase awareness of the impact of race, ethnicity, culture, and class on clinical decision making, and
- develop the clinical staff skills for cross-cultural assessment, communication, and negotiation.

5-Year Expected Outcome for Provider and Patients:

Organizational cultural competence is an important component of patient-centered care and has the potential to improve access to care, quality of care, and, ultimately, health outcomes. A patient's own limited health literacy level, affected in part by cultural and ethnic barriers in language and understanding, can further impede communication. PMH believes it can serve as a catalyst for driving the development and maintenance of individual provider cultural competence by providing the leadership, policies, and systems to support the awareness of culturally competent care with our patients. Providence health professionals must provide clear, understandable, evidence based health information to the Providence patient population. With clear communication, Providence will expect to contribute to the patient's understanding of their disease process, self-management concepts and what resources are available to them throughout their transitions. Through this project, the expectation is to improve the patient experience as well as to improve the patient's understanding of their responsibility to their healthcare, thus, reducing preventable readmissions and improvement of their overall well-being.

Starting Point/Baseline:

A demographic evaluation will be made of all employees, to include, race, languages spoken, and education level. In addition, the facility will inventory all available training materials specific to cultural competency.

Rationale:

The 2010 US Census reported the United States population has become more diverse than ever before, and this trend is expected to continue over this century. In El Paso, the minority is the majority with 80.7 percent of the population being Hispanic, as compared to a 16.7 percent Hispanic population in the United States and a 37.6 percent Hispanic population in Texas. A

diverse staff does not necessarily equal cultural competence. Cultural competency is defined as the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural and linguistic needs. Some gaps at the organizational level in the identified hospital are as follows

- no certified or trained interpreters,
- no evidence of policies specific to different cultures,
- lack of policy flexibility to make allowances for the needs of different cultures (e.g. visitation, environmental consideration),
- no training for direct patient care providers on identifying health literacy, and
- minimal culturally diverse patient and cafeteria meal selections.

As El Paso becomes a more ethnically and racially diverse city, our health care systems and providers need to recognize and address the unique culture and health literacy of a diverse patient population. Failure to understand and manage socio-cultural differences may have significant health consequences for minority groups in particular. Systems lacking culturally and linguistically appropriate health education materials lead to patient dissatisfaction, poor comprehension and adherence, and lower-quality care. Low health literacy creates difficulties in communicating with clinicians, poses barriers in managing chronic illness, lessens the likelihood of receiving preventive care, heightens the possibility of experiencing serious medication errors, increased risk of hospitalization, and results in poorer quality of life.

Project Components:

This project will accomplish the following project components:

f) Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels.
    - Providence will develop such a program under this project.

g) Conduct quality improvement for the project using methods such as rapid-cycle improvement. 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.
    - Providence will continue to improve the program developed under this project by conducting quality improvement activities following the implementation of the program.
        - The instructional program's effectiveness will be measured in several ways. The over-arching goal is to provide culturally appropriate care to patients who present to the health care organization for treatment. Effectiveness will be measured by:
        - Nursing staff will complete the training and have cultural competence validated with a competency-based tool. The validation will be based on passing an examination ($\geq$ 80%), and direct observation in the clinical area. The direct observation will be conducted using unit-based educators.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

Providence's project for driving the development and maintenance of individual provider cultural competence by providing the leadership, policies, and systems to support the awareness of culturally competent care with our patients. This will be a new initiative for PMH.

Related Category 3 Outcome Measures:

OD-6: Patient Satisfaction
IT-6.1: Percent improvement over baseline of patient satisfaction scores
130601104.3.2

Reasons/rationale for selecting the outcome measures:

As this project is implemented and culturally competent care is enhanced, Providence believes that patients will receive more effective care, which will result in an improvement in patient satisfaction scores for the target population of the project. Specifically, Providence expects that the successful implementation of this project will be evidenced by an improvement in patients' ratings of the communication skills of their health care providers.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Tenet's Expand Primary Care Access project (130601104.1.1) and Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2); each of these projects is intended to improve the patient experience by providing care in more effective and efficient ways.

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

This project is congruent with an Enhance Interpretation Services and Culturally Competent Care project to be performed in RHP Region 15 by Sierra Providence East Medical Center (196829901.1.2).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will

continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$4,617,986. In determining the value of this project, Tenet considered the extent to which providing more culturally competent care will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Tenet considered the needs of the large Hispanic population in the El Paso community, as well as the effort that will be required to develop a culturally competent care training program specific to the needs of this population and to implement it by training health care providers at Providence.

Tenet plans to implement a similar Category 1 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.1.2	*1.4.4*	*1.4.4*	*ENHANCE INTERPRETATION SERVICES AND CULTURALLY COMPETENT CARE*
Providence Memorial Hospital			*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.2*	*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]: Conduct an analysis to determine gaps in language access and culturally competent care. Metric 1 [P-1.1]: Gap analysis. Baseline/Goal: Completion of analysis. Data Source: Gap analysis. Milestone 2 Estimated Incentive Payment: $564,698 **Milestone 2** [P-2]: Develop a program to enhance organizational, systemic, or clinical cultural competence as described in the project options. Metric 1 [P-2.1]: Develop and implement program to improve cultural competence. Baseline/Goal: Development and implementation of program. Data Source: Program materials. Milestone 2 Estimated Incentive Payment: $564,698	**Milestone 3** [P-8]: Develop program to improve staff cultural competency and awareness. Metric 1 [P-8.1]: Increase number of champions/staff that are designated and trained in a population's culture and unique needs. Baseline/Goal: 150 employees. Data Source: HR workforce training data; program materials. Patient impact: we expect that 75 champions will be able to provide about 18,616 patient interactions per year. Milestone 4 Estimated Incentive Payment: $1,232,110	**Milestone 4** [I-18]: Implement intervention to increase access to language services and culturally competent care. Metric 1 [I-18.1]: Increase percentage of target population reached. Baseline/Goal: 10% increase in patient interactions by an employee trained in culturally competent care. Data Source: Documentation of target population reached, as designated in the project plan. Patient impact: we expect that trained champions will be able to provide about 20,448 total patient interactions per year. Milestone 4 Estimated Incentive Payment: $1,235,692	**Milestone 5** [I-18]: Implement intervention to increase access to language services and culturally competent care. Metric 1 [I-18.1]: Increase percentage of target population reached. Baseline/Goal: 25% increase in patients that receive care from an employee trained in culturally competent care from the DY3 baseline. Data Source: Documentation of target population reached, as designated in the project plan. Patient impact: we expect that trained champions will be able to provide about 23,270 total patient interactions per year. Milestone 5 Estimated Incentive Payment: $1,020,789
Year 2 Estimated Milestone Bundle Amount: $1,129,396	Year 3 Estimated Milestone Bundle Amount: $1,232,110	Year 4 Estimated Milestone Bundle Amount: $1,235,692	Year 5 Estimated Milestone Bundle Amount: $1,020,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,617,986			

93798

Project Option 1.9.1: Expand high impact specialty care capacity in most impacted medical specialties: **EXPAND SPECIALTY CARE CAPACITY**

Unique Project ID: 130601104.1.3

Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 130601104

Project Summary:

Provider: Providence Memorial Hospital (Providence) is a 508 bed, acute care facility in El Paso Texas. Providence provides pediatric services to the El Paso community, which has a population of about 665,000. HHSC has also designated Providence as a Major Safety Net Hospital in Region 15.

Intervention(s): This project will entail the performance and implementation of a community needs assessment to determine specialties that are underserved at Providence's facility in DY2, recruitment of a specialist and staff as needed and formation or expansion of two specialty clinics in DY3 to better meet the needs of the El Paso community, and expansion of specialty provider clinic hours in DY4 to increase the availability of specialist services. This project will not directly serve any patients in DY2 and DY3, as the recruitment and retention of 2 specialist and establishing or expanding two additional clinics will be the focus in these years to prepare for improvements in patient benefit. In DY3, we expect about 1000 additional patient visits as a result of the two the additional providers, and about 1,344 in DY5 due to an increase in specialist provider hours.

Need for the project: There is a severe shortage of specialty care providers in El Paso County and the surrounding region. A recent assessment revealed a shortage of 100 specialty providers for the population demand. This shortage, coupled with the shortage of primary care in the area, represents a severe lack of access to healthcare in the greater El Paso region. In turn, this lack of access to care has an untoward effect on the overall wellbeing of the population.

Based on internal reports from 2010 and 2011 data, Providence is experiencing shortages in many specialties, with the largest deficits being in Hematology/Oncology, Orthopedic Surgery, and Urology. Based on the gap analysis conducted in DY2, Providence will identify and pursue two specialists and support staff for needed specialty service areas.

Target population: Primary Service Area with population of 665,000. Approximately 40% of patients seen facility-wide are Medicaid eligible or uninsured. Because this project represents a new specialty service area, it is not clear how many patients will be served, but we expect that a similar percentage of Medicaid eligible and uninsured patients will benefit from the implementation of this project. Providence expects that recruiting two additional providers in

DY2 and establishing or expanding two specialty clinics in DY3 will increase patient visits by about 1,344 visits in DY5.

Category 1 or 2 expected patient benefits: Based on the gap analysis conducted in DY2, Providence will identify and pursue a specialist and support staff for two needed specialty service areas. Based on 2012 data, each surgical specialty clinic operates about 16 hours per week, and each medical specialty clinic operates about 32 hours per week. This project will add one specialist provider, establish a new, or expand an existing specialty clinic (depending on the provider recruited), which will increase the provider hours by about 1000 hours in DY4, and 1,344 hours in DY5. This increase in specialist provider hours will allow more patients to access specialty services in the El Paso community.

Category 3 outcomes: As this project is implemented and specialty care clinics are established or expanded, Providence believes that patients will have better access to specialty care, which will result in an improvement in patient satisfaction scores for the target population of the project.

Project Description:

This project will entail the performance and implementation of a community needs assessment to determine specialties that are underserved at Providence's facility in DY2, recruitment of two specialists and staff as needed and formation or expansion of two specialty clinics in DY3 to better meet the needs of the El Paso community, and expansion two specialty provider clinic hours in DY4 to increase the availability of specialist services.

Providence is committed to increasing the access to primary and specialty care, as evidenced by its history of recruitment efforts. The establishment or expansion of two specialty clinics, based on the demand of these targeted services will increase access to much needed care. In addition, it will support population health, and the overall wellbeing of our community, by increasing the number of specialty providers and specialty services based on the identified community need. Providence foresees the identification, recruitment, and retention of specialty physicians as the major challenge with respect to the implementation of this project.

Goals and Relationship to Regional Goals:

Project Goals: The end goal of this project will be the launch of at least two specialty clinics, based on a community needs assessment that will also form the basis for a targeted specialty physician recruitment plan.

This project meets the following regional goals: Utilizing a community assessment to identify the community need for specialist services and target recruitment efforts, will align to the regional goals of increasing the number of specialists and scope of services offered in the community; and the patient experience through delivery of high-quality, effective healthcare services.

Challenges:

Providence foresees the identification, recruitment and retention of specialty physicians as the major challenge with respect to the implementation of this project. Providence will work to identify and recruit two specialist physicians and establish or expand specialty clinics to increase the number of specialty patient visits available.

5-Year Expected Outcome for Provider and Patients:

The expected outcome of the establishment of two specialty clinics, based on the demand of these targeted services, is the increase of specialty care access to much meet the need of these services. In addition, Providence expects to support the population health and the overall wellbeing of our community by increasing the number of specialty providers and specialty services based on the identified community need. The expectation is that Providence will implement and maintain quality improvement activities related to clinic operations, patient experience and overall outcomes so as to ensure the delivery of quality healthcare to the region.

Starting Point/Baseline:

The deficit of physician specialists in the primary service area of Providence is in excess of 50 providers, as of December 2011. Based on the community needs assessment, Providence Memorial Hospital will establish specialty clinics within the community. Based on internal reports from 2010 and 2011 data, Providence is experiencing shortages in many specialties, with the largest deficits being in Hematology/Oncology, Orthopedic Surgery, and Urology. Based on the gap analysis conducted in DY2, Providence will identify and pursue a specialist and support staff for a needed specialty service area. Based on 2012 data, each surgical specialty clinic operates about 16 hours per week, and each medical specialty clinic operates about 32 hours per week. This project will establish a new, or expand an existing specialty clinic (depending on the provider recruited), which will increase the provider hours by about 1000 hours in DY4, and 1,344 hours in DY5.

Rationale:

There is a severe shortage of specialty care providers in El Paso County and the surrounding region. A recent assessment revealed a shortage of 100 specialty providers for the population demand. This shortage, coupled with the shortage of primary care in the area, represents a severe lack of access to healthcare in the greater El Paso region. In turn, this lack of access to care has an untoward effect on the overall wellbeing of the population. Before there can be an expansion of specialty care and services, it is crucial to perform a gap analysis regarding health disparities in the region and the particular need for specialists in specific practice areas and geographic areas.

Project Components:

This project will accomplish the following project components:

a) Identify high impact/most impacted specialty services and gaps in care and coordination

- In DY2, Providence will conduct a gap analysis to determine shortage by specialty area for the facility.

b) Increase the number of residents/trainees choosing targeted shortage specialties

- In DY3, Providence will identify, recruit, and retain two specialists in the specialty areas identified by the DY2 gap analysis. Providence will also undergo an analysis to determine the extent to which support staff and personnel will be necessary.

c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)

- As part of the recruitment efforts in DY2, Providence will establish a committee to develop unique recruitment strategies and analyze ways that the facility can improve retention efforts for current team members.

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.

- Throughout the Waiver, Providence will continue to participate in RHP meetings held by the Anchor, and will conduct quarterly internal meetings to ensure that this project is implemented and successfully integrated into the overall facility healthcare delivery framework.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care

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

Providence has been committed to increasing the access to primary and specialty care, which is evidenced by its history of recruitment efforts. Through a detailed and deliberate community gap analysis in DY2 and a commitment to implement and maintain quality improvement activities related to clinic operations, patient experience and overall quality outcomes, this project will represent an ENHANCED initiative.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction
IT-6.1: Percent improvement over baseline of patient satisfaction scores
130601104.3.3

Reasons/rationale for selecting the outcome measures:

As this project is implemented and two new specialists are recruited and retained to fill needed areas of specialty care at the facility, Providence believes that patients will have better access to specialty care, which will result in an improvement in patient satisfaction scores for the target population of the project. Specifically, Providence expects that the successful implementation of

this project will be accompanied by an improvement in patients' rating of their access to specialty care in the target population – those patients that utilize the new specialty services or specialty clinic.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Providence's Expand Primary Care Access project (130601104.1.1) in developing and expanding a robust community-wide network of primary care and specialty care services in El Paso.

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

This project is congruent with an Expand Specialty Care Capacity project to be performed in RHP Region 15 by Sierra Providence East Medical Center (196829901.1.3).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$6,717,071. In determining the value of this project, Providence considered the extent to which increased access to specialty care will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Providence considered the value to the community of a project such as this, which will be specifically targeted to identified specialty services needs of the community. In addition, Providence considered the difficulty of recruiting and retaining specialty physicians in the El Paso area.

Tenet plans to implement a similar Category 1 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East. Additionally, Providence will be hiring two specialists and establishing or expanding two specialty clinics, whereas Sierra East will focus on one specialty provider.

130601104.1.3	***1.9.1***	***1.9.1.A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Providence Memorial Hospital				*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.3*	*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-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period. Baseline/Goal: Completed needs assessment. Data Source: Needs assessment. Patient Impact: 0 specialty patient visits Milestone 1 Estimated Incentive Payment: $1,642,757	**Milestone 2** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of specialist providers by 2 based on the DY2 gap analysis Data Source: HR documents or other documentation demonstrating employed/contracted specialists. Patient Impact: 0 specialty patient visits Milestone 2 Estimated Incentive Payment: $896,080 **Milestone 3** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish/expand specialty care clinics. Baseline/Goal: Establish or expand at least 2 new clinics. Data Source: Documentation of new/expanded specialty care clinic. Milestone 3 Estimated Incentive Payment: $896,080		**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of clinic hours at the facility by 1000 hours. Data Source: Clinic Schedules demonstrating increased hours of availability. Patient Impact: 1000 additional specialty patient visits Milestone 4 Estimated Incentive Payment: $1,797,370	**Milestone 5** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of clinic hours at the facility by 1,344 hours. Data Source: Clinic Schedules demonstrating increased hours of availability. Patient Impact: 1,344 additional specialty patient visits Milestone 5 Estimated Incentive Payment: $1,484,784

130601104.1.3	***1.9.1***	***1.9.1.A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Providence Memorial Hospital				*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.3*	*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: $1,642,757	Year 3 Estimated Milestone Bundle Amount: $1,792,160		Year 4 Estimated Milestone Bundle Amount: $1,797,370	Year 5 Estimated Milestone Bundle Amount: $1,484,784
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,717,071				

93848

Project Option 1.1.2: Expand existing primary care capacity: **EXPAND PRIMARY CARE ACCESS**

Unique Project ID: 196829901.1.1

Performing Provider Name/TPI: Sierra Providence East Medical Center / TPI: 196829901

Project Summary:

Provider: Sierra Providence East Medical Center is a 110 bed, acute care facility in Far East El Paso Texas. Its primary service area serves a population of approximately 331,000 over 5 contiguous zip codes.

Intervention(s): This project will establish one Urgent Care Center and hire personnel to staff the clinic in DY3 to ensure the Medicaid and uninsured patient population have access to the appropriate venue for care.

Need for the project: El Paso has a severe shortfall of available primary care physicians and facilities available to support primary care for prevention and chronic care management. Currently the facilities' Emergency Department is being utilized for primary care as evident by 30% of non-urgent visits.

Target population: The target population is our patients that currently using the Emergency Department for non-urgent conditions. Approximately 18% of the ED patients are uninsured and approximately 36% of the ED patients are insured by Medicaid. Although we cannot accurately predict the number of patients that will benefit from expanded Urgent Care availability, we expect that a similar percentage of those patients served will be either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: Increasing primary care access through the establishment of an Urgent Care facility with an increase in hours of availability based on the needs of the population will provide the patients with a more effective and efficient primary care alternative. We do not expect any patients to benefit directly from this project in DY2, as Sierra East will be conducting a gap analysis to determine the location, population, and services that will be covered by the Urgent Care Center. We expect about 2,534 patients will be seen in DY3, 2,845 in DY4, and 3,417 in DY5 as a result of the establishment of this new Urgent Care Center.

Category 3 outcomes: Establishing an Urgent Care clinic location will make it more convenient for patients to choose primary care over emergent care, thereby making it more likely that they will do so, increasing patient satisfaction, and improving the quality of the patient experience while reducing the overall cost of care.

Project Description:

This project will establish one Urgent Care Center and hire personnel to staff the clinic in DY3 to ensure the Medicaid and uninsured patient population have access to the appropriate venue for care.

Increased access to primary care will help address a substantial need in the community for increased access to primary care. Additionally, seeing patients in an ambulatory setting will promote the appropriate level of care in the appropriate setting and reduces unnecessary ED admissions for conditions better served in a clinic setting.

Target Zip Codes: 79927

Goals and Relationship to Regional Goals:

Project Goals: A primary goal of this project is increasing access to primary care for the population served, promoting the appropriate level of care in the appropriate setting and reducing unnecessary ED admissions for conditions better served in a clinic setting, thus containing costs and healthcare infrastructure. The project will also promote the appropriate redirection of patients to Urgent Care locations, resulting in promoting better health outcomes, improvement of patient experience and reduced cost of services provided. The project will also involve education of the public specific to understanding "emergent versus urgent" conditions.

This project meets the following regional goals: Expanding hours of coverage, locations, and staffing of Urgent Care Centers to ensure the Medicaid and uninsured patient population has access to the appropriate venue for care, aligns to the goals of the Region, by increasing access to primary care. Additionally, seeing patients in an ambulatory setting will promote the appropriate level of care in the appropriate setting which aligns itself to a Regional goal as well. This project also allows us, during the redirection of patients from the ED, to provide patient education to ensure the population is accessing the right care in the right setting and promotes a better patient experience through delivery of high-quality, effective healthcare services, which aligns to the goals of our Region.

Challenges:

A major challenge facing the project is the high volume of uninsured and unfunded patients utilizing the Emergency Room. This project seeks to redirect non-emergent patients to an Urgent Care Center, which provides a more appropriate level of care. This will also reduce wait times and improve outcomes for those patients that have injuries or a condition that requires emergency attention because the non-emergent patients will have greater access to services other than the emergency room.

5-Year Expected Outcome for Provider and Patients:

This project will establish one new Urgent Care Center and hiring/training the professional staff for the clinic in DY3. Research shows that a strong primary care system can improve health outcomes and reduce health care costs. Primary care can also reduce costs by increasing access to preventive care. Sierra East believes the severe shortfall of available primary care physicians and facilities available to support primary care for prevention and chronic care management in the El Paso region, could affect why the El Paso region does not have health outcomes that correspond to our overall investment in healthcare. Thus, Sierra East believes that strengthening and growing our primary care workforce is critical to reforming the regions' health care system. Sierra East believes that increasing access to primary care physicians and nurses can help prevent disease and illness and ensure our El Paso Region have access to high quality care.

Starting Point/Baseline:

Analysis of Emergency Department visits, classified as non-urgent and urgent, will provide the target population and medical conditions to develop protocols and education to redirect patients to the appropriate setting. Patient populations with multiple visits to the emergency department for urgent and non-urgent conditions will be evaluated to determine deterrents to primary care access.

Rationale:

It is well known the national supply of primary care does not meet the demand for primary care services. Moreover, it is a key goal of health care improvement to provide more preventative and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. Over 30% of Emergency Room visits are visits that could be seen in an Urgent Care setting. At present, many of the ED visits present in late afternoon and evening hours, when primary care offices are closing. Expansion of Urgent Care clinic hours will make it possible for those patients to be redirected to a more efficient and effective site of care, rather than giving them no choice but to present at an ED for costlier treatment with which patients may be less satisfied. Expansion of Urgent Care clinic staffing will make it possible to expand the clinics' hours. Expansion of Urgent Care clinic locations will make it more convenient for patients to choose primary care over emergent care, thereby making it more likely that they will do so, increasing patient satisfaction, and improving the quality of the patient experience while reducing the overall cost of care.

Project Components:

This project will accomplish the following project components:

b) Expand primary care clinic space in DY3.
   - Sierra East will expand its primary care locations.

c) Expand primary care clinic hours in DY3.
   - Sierra East will expand its primary care hours of coverage by opening a new clinic site.

d) Expand primary care clinic staffing.
   - Sierra East will expand its primary care clinic staffing in DY3.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care

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

Expanding hours of coverage, locations, and staffing of Urgent Care Centers to ensure the Medicaid and uninsured patient population has access to the appropriate venue for care will be an NEW initiative for Sierra East.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

IT-6.1: Percent improvement over baseline of patient satisfaction scores

196829901.3.1

Reasons/rationale for selecting the outcome measures:

As this project is implemented and Urgent Care Centers are made more available and accessible to the patient population, Sierra East believes that patients will have better access to primary care, which will result in an improvement in patient satisfaction scores for the target population of the project. Specifically, Sierra East expects that the successful implementation of this project will be evidenced by an improvement in patients' ratings of access to care in the target population.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Tenet's Enhance Interpretation Services and Culturally Competent Care project (196829901.1.2) and Implement/Expand Care Transitions project (196829901.2.1); each of these projects is intended to improve the patient experience by providing care in more effective and efficient ways. Furthermore, this project will complement Tenet's Expand Specialty Care Capacity project (196829901.1.3) in developing and expanding a robust community-wide network of primary care and specialty care services in El Paso.

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

This project is congruent with an Expand Primary Care Access project to be performed in RHP Region 15 by Providence Memorial Hospital (130601104.1.1).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$4,714,113. In determining the value of this project, Tenet considered the extent to which increased access to primary care through expanding its primary care clinics will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Tenet considered the significant cost savings that will result from the successful implementation of this project when patients are navigated away from high-cost treatment sites such as Emergency Rooms, as well as the significant investment that will be necessary to implement the project.

Tenet plans to implement a similar Category 1 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196829901.1.1	***1.1.2***	***1.1.2.A-C***	***EXPAND PRIMARY CARE ACCESS***	
Sierra Providence East Medical Center				*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.1*	*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-X]: Conduct needs assessment for Urgent Care Center location, services to be offered at the Urgent Care Center, and staffing that will be required to support the Urgent Care Center. Baseline/Goal: There are currently 0 UCCs and 0 patient visits for the Sierra East facility. Submit one assessment for new UCC location. Data Source: Assessment Results Milestone 1 Estimated Incentive Payment: $1,152,905	**Milestone 2** [P-1]: Establish additional/expand existing/relocate primary care clinics. <u>Metric 1</u> [P-1.1]: Number of additional clinics or expanded hours or space. Baseline/Goal: Establish 1 primary care clinic Data Source: New primary care schedule. Milestone 2 Estimated Incentive Payment: $419,253 **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: Increase of 2,534 patient visits over DY2 baseline. Data Source: Registry, EHR, or claims at UCC. Milestone 3 Estimated Incentive Payment: $419,253 **Milestone 4** [P-5]: Train/hire		**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. Baseline /Goal: Increase of 2,845 patient visits over DY2 baseline. Data Source: Registry, EHR, or claims at UCC. Milestone 5 Estimated Incentive Payment: $1,261,413	**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 number of visits. Demonstrate improvement over prior reporting period. Baseline /Goal: Increase of 3,417 patient visits over DY2 baseline. Data Source: Registry, EHR, or claims at UCC. Milestone 6 Estimated Incentive Payment: $1,042,037

196829901.1.1	***1.1.2***	***1.1.2.A-C***	***EXPAND PRIMARY CARE ACCESS***	
Sierra Providence East Medical Center				*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.1*	*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)**
	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. Baseline/Goal: Addition of at least 1 primary care provider based on the needs assessment. Data Source: HR documentation of staffing at UCC. Milestone 4 Estimated Incentive Payment: $419,252			
Year 2 Estimated Milestone Bundle Amount: $1,152,905	Year 3 Estimated Milestone Bundle Amount: $1,257,757		Year 4 Estimated Milestone Bundle Amount: $1,261,413	Year 5 Estimated Milestone Bundle Amount: $1,042,037
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,714,113				

93814

Project Option 1.4.4: Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels; the curricula should increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors; address the impact of race, ethnicity, culture, and class on clinical decision making; develop tools to assess the community members' health beliefs and behaviors; develop human resource skills for cross-cultural assessment, communication, and negotiation: **ENHANCE INTERPRETATION SERVICES AND CULTURALLY COMPETENT CARE**

Unique Project ID: 196829901.1.2

Performing Provider Name/TPI: Sierra Providence East Medical Center (Sierra East) / TPI: 196829901

Project Summary:

Provider: Sierra Providence East Medical Center (Sierra East) is a 110 bed, acute care facility in Far East El Paso Texas. Its primary service area serves a population of approximately 331,000 over 5 contiguous zip codes.
Intervention(s): This project will involve the design and development of a program to improve the cultural competency of Sierra East staff as well as staff competency in assessment of health literacy**.** This program will develop a cross-cultural training curriculum that will:

- offer a cross-cultural training program that is an integrated component of the training and professional development of all clinical staff;
- increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors;
- increase awareness of the impact of race, ethnicity, culture, and class on clinical decision making, and
- develop the clinical staff skills for cross-cultural assessment, communication, and negotiation.

Need for the project: Currently there is not a formal program regarding the concept of cultural competent care or health literacy. This results in the lack of knowledge regarding health literacy, and the assumption that the staff is culturally competency due to Hispanic staff caring for Hispanic population. A diverse staff does not necessarily equal cultural competence. Cultural competency is defined as the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural and linguistic needs. Some gaps at the organizational level in the identified hospital are as follows

- no certified or trained interpreters,
- no evidence of policies specific to different cultures,
- lack of policy flexibility to make allowances for the needs of different cultures (e.g. visitation, environmental consideration),
- no training for direct patient care providers on identifying health literacy, and
- minimal culturally diverse patient and cafeteria meal selections.

Target population: The target population is all admitted inpatients of Sierra East, and will focus on those patients needing enhanced cultural and language attention from our staff. Our goal is to ensure that each patient receives high-quality care regardless of background or language barriers. Approximately 36% of patients seen facility-wide are Medicaid eligible or indigent patients. Based on the correlation between poverty and minority populations in El Paso, it is likely that this project will affect a higher percentage of Medicaid eligible and indigent patents that our facility-wide average.

Category 1 or 2 expected patient benefits: Based on the needs identified in an organizational needs assessment and a community-wide gap analysis, Sierra East will develop a program to improve cultural competence will be developed and implemented. In addition, the concept of Health Literacy along with tools and techniques will be introduced. With clear communication, Sierra East expects to contribute to the patient's understanding of their disease process, self-management concepts and what resources are available to them throughout their transition. We do not expect any direct patient impact in DY2, as Sierra East will be conducting gap analysis to determine areas for improvement in culturally competent care and developing a training program to enhance the organization's cultural competence. We expect that the 75 trained champions will be able to accomplish about 9,308 patient interactions in DY3, 10,238 in DY4, and 11,635 in DY5.

Category 3 outcomes: Enhancement of culturally competent care will promote care that is patient centered. This will result in an overall improvement of the patient experience as evidenced by an improvement in patients' ratings of the communication skills of their health care providers

Project Description:

This project will improve effective communication by designing and developing a program to improve the cultural competency of Sierra East staff as well as staff competency in assessment of health literacy.

This goal of this project will be to design and develop a program to improve the cultural competency of the staff as well as competency in assessment of health literacy for the improvement of effective communication. Tenet believes that effective health communication is as important to health care as clinical skill. Tenet is committed to improving individual health and building healthy communities, and Tenet wishes to support our health care providers as they recognize and address the unique culture and health literacy of our diverse patient population. When this support is provided, patients will have access to qualified health care in their primary language and will support the likelihood of safe and effective care, open communication, adherence to treatment protocols, and better health outcomes. This project will involve the implementation of organizational performance improvement and transformational activities that spread learning and awareness, thereby building patient/provider communications that are culturally competent and health-literacy aware.

Goals and Relationship to Regional Goals:

Project Goals: A major goal of the project will be the improvement of patient experience as evidenced by improvement of Nurse/Physician communication scores and overall program scores on patient assessment tools.

This project meets the following regional goals: There is consensus about the nature and importance of cultural competence as an essential component of accessible, responsive, and high quality health care. Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes. This project will align to the Regional goals of improvement of the management patients with chronic diseases, to help prevent unnecessary readmission and providing patients the care they need to prevent disease and to self-manage their disease process. The intent of the this project will support the Regional goals of overcoming language barriers to accessing healthcare resources in the region and increase the patient experience through delivery of high-quality, effective healthcare services.

Challenges:

Challenges facing the project include the current lack of knowledge regarding health literacy, and the assumption of culturally competency of staff due to Hispanic staff caring for Hispanic population. Challenges will be met by identifying the goal or desired change and the development of a cross-cultural training curriculum that will:

- offer a cross-cultural training program that is an integrated component of the training and professional development of all clinical staff;
- increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors;
- increase awareness of the impact of race, ethnicity, culture, and class on clinical decision making, and
- develop the clinical staff skills for cross-cultural assessment, communication, and negotiation.

5-Year Expected Outcome for Provider and Patients:

Organizational cultural competence is an important component of patient-centered care and has the potential to improve access to care, quality of care, and, ultimately, health outcomes. A patient's own limited health literacy level, affected in part by cultural and ethnic barriers in language and understanding, can further impede communication. Sierra Providence East believes it can serve as a catalyst for driving the development and maintenance of individual provider cultural competence by providing the leadership, policies, and systems to support the awareness of culturally competent care with our patients. Sierra East health professionals must provide clear, understandable, evidence based health information to the Sierra East patient population. With clear communication, Sierra East will expect to contribute to the patient's understanding of their disease process, self-management concepts and what resources are available to them throughout their transitions. Through this project, the expectation is to improve the patient experience as well as to improve the patient's understanding of their responsibility to their healthcare, thus, reducing preventable readmissions and improvement of their overall well-being.

Starting Point/Baseline:

A demographic evaluation will be made of all employees, to include, race, languages spoken, and education level. In addition, the facility will inventory all available training materials specific to cultural competency.

Rationale:

The 2010 US Census reported the United States population has become more diverse than ever before, and this trend is expected to continue over this century. In El Paso, the minority is the majority with 80.7 percent of the population being Hispanic, as compared to a 16.7 percent Hispanic population in the United States and a 37.6 percent Hispanic population in Texas. A diverse staff does not necessarily equal cultural competence. Cultural competency is defined as the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural and linguistic needs. Some gaps at the organizational level in the identified hospital are as follows

- no certified or trained interpreters,
- no evidence of policies specific to different cultures,
- lack of policy flexibility to make allowances for the needs of different cultures (e.g. visitation, environmental consideration),
- no training for direct patient care providers on identifying health literacy, and
- minimal culturally diverse patient and cafeteria meal selections.

As El Paso becomes a more ethnically and racially diverse city, our health care systems and providers need to recognize and address the unique culture and health literacy of a diverse patient population. Failure to understand and manage socio-cultural differences may have significant health consequences for minority groups in particular. Systems lacking culturally and linguistically appropriate health education materials lead to patient dissatisfaction, poor comprehension and adherence, and lower-quality care. Low health literacy creates difficulties in communicating with clinicians, poses barriers in managing chronic illness, lessens the likelihood of receiving preventive care, heightens the possibility of experiencing serious medication errors, increased risk of hospitalization, and results in poorer quality of life. .

Project Components:

This project will accomplish the following project components:

h) Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels.
    - Sierra East will develop such a program under this project.

i) Conduct quality improvement for the project using methods such as rapid-cycle improvement. 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.
    - Sierra East will continue to improve the program developed under this project by conducting quality improvement activities following the implementation of the program.

- The instructional program's effectiveness will be measured in several ways. The over-arching goal is to provide culturally appropriate care to patients who present to the health care organization for treatment. Effectiveness will be measured by:
- Nursing staff will complete the training and have cultural competence validated with a competency-based tool. The validation will be based on passing an examination (≥ 80%), and direct observation in the clinical area. The direct observation will be conducted using unit-based educators.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

Sierra Providence East project for driving the development and maintenance of individual provider cultural competence by providing the leadership, policies, and systems to support the awareness of culturally competent care with our patients. This will be a NEW initiative for Sierra East.

Related Category 3 Outcome Measures:

OD-6: Patient Satisfaction

IT-6.1: Percent improvement over baseline of patient satisfaction scores

196829901.3.2

Reasons/rationale for selecting the outcome measures:

As this project is implemented and culturally competent care is enhanced, Sierra East believes that patients will receive more effective care, which will result in an improvement in patient satisfaction scores for the target population of the project. Specifically, Sierra East expects that the successful implementation of this project will be evidenced by an improvement in patients' ratings of the communication skills of their health care providers.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Tenet's Expand Primary Care Access project (196829901.1.1) and Enhance Interpretation Services and Culturally Competent Care project (196829901.1.2); each of these projects is intended to improve the patient experience by providing care in more effective and efficient ways.

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

This project is congruent with an Enhance Interpretation Services and Culturally Competent Care project to be performed in RHP Region 15 by Providence Memorial Hospital (130601104.1.2).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$2,592,762. In determining the value of this project, Tenet considered the extent to which providing more culturally competent care will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Tenet considered the needs of the large Hispanic population in the El Paso community, as well as the effort that will be required to develop a culturally competent care training program specific to the needs of this population and to implement it by training health care providers at Sierra East.

Tenet plans to implement a similar Category 1 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196829901.1.2	*1.4.4*	*1.4.4*	*ENHANCE INTERPRETATION SERVICES AND CULTURALLY COMPETENT CARE*
Sierra Providence East Medical Center			*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.2*	*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]: Conduct an analysis to determine gaps in language access and culturally competent care. Metric 1 [P-1.1]: Gap analysis. Baseline/Goal: Completion of analysis. Data Source: Gap analysis. Milestone 2 Estimated Incentive Payment: $317,049 **Milestone 2** [P-2]: Develop a program to enhance organizational, systemic, or clinical cultural competence as described in the project options. Metric 1 [P-2.1]: Develop and implement program to improve cultural competence. Baseline/Goal: Development and implementation of program. Data Source: Program materials. Milestone 2 Estimated Incentive Payment: $317,049	**Milestone 3** [P-8]: Develop program to improve staff cultural competency and awareness. Metric 1 [P-8.1]: Increase number of champions/staff that are designated and trained in a population's culture and unique needs. Baseline/Goal: 75 employees. Data Source: HR workforce training data; program materials. Patient impact: we expect that 75 champions will be able to provide about 9,308 patient interactions per year. Milestone 4 Estimated Incentive Payment: $691,766	**Milestone 4** [I-18]: Implement intervention to increase access to language services and culturally competent care. Metric 1 [I-18.1]: Increase percentage of target population reached. Baseline/Goal: 10% increase in patient interactions by an employee trained in culturally competent care. Data Source: Documentation of target population reached, as designated in the project plan. Patient impact: we expect that trained champions will be able to provide about 10,238 total patient interactions per year. Milestone 4 Estimated Incentive Payment: $693,777	**Milestone 5** [I-18]: Implement intervention to increase access to language services and culturally competent care. Metric 1 [I-18.1]: Increase percentage of target population reached. Baseline/Goal: 25% increase in patients that receive care from an employee trained in culturally competent care from the DY3 baseline. Data Source: Documentation of target population reached, as designated in the project plan. Patient impact: we expect that trained champions will be able to provide about 11,635 total patient interactions per year. Milestone 5 Estimated Incentive Payment: $573,120
Year 2 Estimated Milestone Bundle Amount: $634,098	Year 3 Estimated Milestone Bundle Amount: $691,766	Year 4 Estimated Milestone Bundle Amount: $693,777	Year 5 Estimated Milestone Bundle Amount: $573,120
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,592,762			

93807

Project Option 1.9.1: Expand high impact specialty care capacity in most impacted medical specialties: **EXPAND SPECIALTY CARE CAPACITY**

Unique Project ID: 196829901.1.3

Performing Provider Name/TPI: Sierra Providence East Medical Center / TPI: 196829901

Project Summary:

Provider: Sierra Providence East Medical Center (Sierra East) is a 110 bed, acute care facility in Far East El Paso Texas. Sierra East's primary service area serves a population of approximately 331,000 over 5 contiguous zip codes.

Intervention(s): This project will entail the performance and implementation of a community needs assessment to determine specialties that are underserved at Sierra East's facility in DY2, recruitment of a specialist and staff as needed and formation or expansion of a specialty clinic in DY3 to better meet the needs of the El Paso community, and expansion of specialty provider clinic hours in DY4 to increase the availability of specialist services. This project will not directly serve any patients in DY2 and DY3, as the recruitment and retention of a specialist and establishing the clinic will be the focus in these years to prepare for improvements in patient benefit. In DY3, we expect about 500 additional patient visits as a result of the additional provider, and about 672 in DY5 due to an increase in specialist provider hours.

Need for the project: There is a severe shortage of specialty care providers in El Paso County and the surrounding region, as identified in the Paso Del Norte Community needs assessment, and reflected in the RHP plan for Region 15. A recent assessment revealed a shortage of 100 specialty providers for the population demand. This shortage, coupled with the shortage of primary care in the area, represents a severe lack of access to healthcare in the greater El Paso region. In turn, this lack of access to care has an untoward effect on the overall wellbeing of the population.

Based on internal reports from 2010 and 2011 data, Sierra East is experiencing shortages in many specialties, with the largest deficits being in Hematology/Oncology, General Surgery, and Orthopedic Surgery. Based on the gap analysis conducted in DY2, Sierra East will identify and pursue a specialist and support staff for a needed specialty service area.

Target population: The target population will be patients that require access to a specialist provider that is not currently available at Sierra Providence East. It is difficult to know how many patients will be treated, because of the wide variation in specialist volume. Sierra East will recruit a specialist based on the gap analysis performed in DY2 Sierra East's facility-wide patient population is about 36% Medicaid-eligible or indigent. Sierra East expects that a comparable percentage of Specialist visits made available through this project will serve this

population. Sierra East expects that recruiting two additional providers and establishing or expanding two specialty clinics will increase patient visits by about 672 visits in DY5.

Category 1 or 2 expected patient benefits: Based on the gap analysis conducted in DY2, Sierra East will identify and pursue a specialist and support staff for a needed specialty service area. Based on 2012 data, each surgical specialty clinic operates about 16 hours per week, and each medical specialty clinic operates about 32 hours per week. This project will add one specialist provider, establish a new, or expand an existing specialty clinic (depending on the provider recruited), which will increase the provider hours by about 500 hours in DY4, and 672 hours in DY5. This increase in specialist provider hours will allow more patients to access specialty services in the El Paso community.

Category 3 outcomes: As this project is implemented and specialty care clinics are established or expanded, Sierra East believes that patients will have better access to specialty care, which will result in an improvement in patient satisfaction scores for the target population of the project.

Project Description:

This project will entail the performance and implementation of a community needs assessment to determine specialties that are underserved at Sierra East's facility in DY2, recruitment of a specialist and staff as needed and formation or expansion of a specialty clinic in DY3 to better meet the needs of the El Paso community, and expansion of specialty provider clinic hours in DY4 to increase the availability of specialist services.

Sierra East is committed to increasing the access to primary and specialty care through its history of recruitment efforts. The establishment of a specialty clinic, based on the demand of these targeted services will increase access to much needed care. In addition, it will support population health, and the overall wellbeing of our community, by increasing the number of specialty providers and specialty services based on the identified community need. Sierra East foresees the identification, recruitment, and retention of specialty physicians as the major challenge with respect to the implementation of this project.

Goals and Relationship to Regional Goals:

Project Goals: The end goal of this project will be the launch of at least one specialty clinic, based on a community needs assessment that will also form the basis for a targeted specialty physician recruitment plan.

This project meets the following regional goals: Utilizing a community assessment to identify the community need for specialist services and target recruitment efforts, will align to the regional goals of increasing the number of specialist and scope of services offered in the community; and the patient experience through delivery of high-quality, effective healthcare services.

Challenges:

Tenet foresees the identification, recruitment, and retention of specialty physicians as the major challenge with respect to the implementation of this project.

5-Year Expected Outcome for Provider and Patients:

Sierra East is committed to increasing the access to primary and specialty care, as evidenced by its history of recruitment efforts. The expected outcome of the establishment of a specialty clinic, based on the demand of these targeted services, is the increase of specialty care access to much meet the need of these services. In addition, Sierra East expects to support the population health, and the overall wellbeing of our community, by increasing the number of specialty providers and specialty services based on the identified community need. The expectation is that Sierra East will implement and maintain quality improvement activities related to clinic operations, patient experience and overall outcomes so as to ensure the delivery of quality healthcare to the region.

Starting Point/Baseline:

The deficit of physician specialists in the east El Paso community is in excess of 150 providers, as of December 2011. Based on the community needs assessment, Sierra East will establish specialty clinics within the community. Based on internal reports from 2010 and 2011 data, Sierra East is experiencing shortages in many specialties, with the largest deficits being in Hematology/Oncology, General Surgery, and Orthopedic Surgery. Based on the gap analysis conducted in DY2, Sierra East will identify and pursue a specialist and support staff for a needed specialty service area. Based on 2012 data, each surgical specialty clinic operates about 16 hours per week, and each medical specialty clinic operates about 32 hours per week. This project will establish a new, or expand an existing specialty clinic (depending on the provider recruited), which will increase the provider hours by about 500 hours in DY4, and 672 hours in DY5.

Rationale:

There is a severe shortage of specialty care providers in El Paso County and the surrounding region. A recent assessment revealed a shortage of 100 specialty providers for the population demand. This shortage, coupled with the shortage of primary care in the area, represents a severe lack of access to healthcare in the greater El Paso region. In turn, this lack of access to care has an untoward effect on the overall wellbeing of the population. Before there can be an expansion of specialty care and services, it is crucial to perform a needs assessment regarding health disparities in the region and the particular need for specialists in specific practice areas and geographic areas.

Project Components:

a) Identify high impact/most impacted specialty services and gaps in care and coordination

- In DY2, Sierra East will conduct a gap analysis to determine shortage by specialty area for the facility.

b) Increase the number of residents/trainees choosing targeted shortage specialties

- In DY3, Sierra East will identify, recruit, and retain a specialist in one of the specialty areas identified by the DY2 gap analysis. Sierra East will also

undergo an analysis to determine the extent to which support staff and personnel will be necessary.

c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)

- As part of the recruitment efforts in DY2, Sierra East will establish a committee to develop unique recruitment strategies and analyze ways that the facility can improve retention efforts for current team members.

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.

- Throughout the Waiver, Sierra East will continue to participate in RHP meetings held by the Anchor, and will conduct quarterly internal meetings to ensure that this project is implemented and successfully integrated into the overall facility healthcare delivery framework.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care

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

Sierra East has been committed to increasing the access to primary and specialty care, which is evidenced by its history of recruitment efforts. Through a detailed and deliberate gap analysis conducted in DY2 and a commitment to implement and maintain quality improvement activities related to clinic operations, patient experience and overall quality outcomes, this project will represent an enhanced initiative.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction
IT-6.1: Percent improvement over baseline of patient satisfaction scores
196829901.3.3

Reasons/rationale for selecting the outcome measures:

As this project is implemented and a specialist is recruited and retained to fill needed areas of specialty care at the facility, Sierra East believes that patients will have better access to specialty care, which will result in an improvement in patient satisfaction scores for the target population of the project. Specifically, Sierra East expects that the successful implementation of this project will be accompanied by an improvement in patients' rating of their access to specialty care in the target population.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving

access to care and containing the costs of care. Specifically, this project will complement Tenet's Expand Primary Care Access project (196829901.1.1) in developing and expanding a robust community-wide network of primary care and specialty care services in El Paso.

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

This project is congruent with an Expand Specialty Care Capacity project to be performed in RHP Region 15 by Providence Memorial Hospital (130601104.1.3).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$3,771,289. In determining the value of this project, Sierra East considered the extent to which increased access to specialty care will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Sierra East considered the value to the community of a project such as this, which will be specifically targeted to identified specialty services needs of the community. In addition, Sierra East considered the difficulty of recruiting and retaining specialty physicians in the El Paso area.

Tenet plans to implement a similar Category 1 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East. Additionally, Providence will be

hiring two specialists and establishing or expanding two specialty clinics, whereas Sierra East will focus on one specialty provider.

196829901.1.3	***1.9.1***	***1.9.1.A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Sierra Providence East Medical Center				*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.3*	*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-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period. Baseline/Goal: Completed needs assessment. Data Source: Needs assessment. Patient Impact: 0 specialty patient visits Milestone 1 Estimated Incentive Payment: $922,324	**Milestone 2** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of specialist providers by 1 based on the DY2 gap analysis Data Source: HR documents or other documentation demonstrating employed/contracted specialists. Patient Impact: 0 specialty patient visits Milestone 2 Estimated Incentive Payment: $503,102 **Milestone 3** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish/expand specialty care clinics. Baseline/Goal: Establish or expand at least 1 new clinic. Data Source: Documentation of new/expanded specialty care clinic. Milestone 3 Estimated Incentive Payment: $503,103		**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of clinic hours at the facility by 500 hours. Data Source: Clinic Schedules demonstrating increased hours of availability. Patient Impact: 500 additional specialty patient visits Milestone 4 Estimated Incentive Payment: $1,009,130	**Milestone 5** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high-impact/most-impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline/Goal: Increase the number of clinic hours at the facility by 672 hours. Data Source: Clinic Schedules demonstrating increased hours of availability. Patient Impact: 672 additional specialty patient visits Milestone 5 Estimated Incentive Payment: $833,630

196829901.1.3	***1.9.1***	***1.9.1.A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Sierra Providence East Medical Center				*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.3*	*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: $922,324	Year 3 Estimated Milestone Bundle Amount: $1,006,205		Year 4 Estimated Milestone Bundle Amount: $1,009,130	Year 5 Estimated Milestone Bundle Amount: $833,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,771,289				

93804

Project Option: 1.9.3. A Proposal to Increase Access to Ocular care to an Underserved Population

Unique Project ID: 084597603.1.1
RHP Performing Provider / TEXAS TECH HS CTR FAMILY MED / 084597603
Project Title: Increasing access to ocular care to an Underserved Population

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will address extremely limited ocular care (a single therapeutic optometrist and no ophthalmologists in the performing provider's practice) in our region by recruiting 4 additional providers (two therapeutic optometrists and two ophthalmologists) and the required staff and technicians, and will facilitate access through the development of an electronic referral system from our primary care clinics to ophthalmology.

Need for the project: Our region has a disproportionate burden of patients with diabetes and the majority of our population is at increased risk of developing diabetes. The current time to 3rd new appointment for our single ocular professional is 59 days. Access to ophthalmologic care in the Region is challenging: Even for patients with full funding, less than 50% of patients with diabetes in a major medicare plan receive an annual eye exam and only 61% of patients at risk of glaucoma have received an evaluation

Target Population:
As noted above, approximately 60% of our organization's ambulatory visits in the current fiscal year are to patients with Medicaid or no insurance. The single current provider provides approximately 4500 patient visits/year, of which more than 80% are to patients with Medicaid or no insurance. These populations will benefit from this project substantially

Category 1 or 2 expected benefits : We will recruit 4 additional ocular professionals to the Region. We will increase the number of unique patients seen by 80% over DY2, and at least 50% of the referrals will be received electronically.

We anticipate DY2 to be a year of planning and recruitment, and confirming the number of unique patients seen annually which we estimate to be 1000. The number of unique patients estimated to be seen by DY is
DY2:1000 DY3:1250 DY4:1500 DY5:1800

The number of patients does not increase linearly with the number of providers because as we add additional providers, we will be providing more complex services than are currently available to this population

These numbers do not reflect the full benefit of this program. There are at least three other tangible benefits this project will accomplish:

1. Each unique patient typically represents multiple visits, so the total number of visits will also increase substantially by DY5
2. This project will provide this vulnerable population access to ophthalmologist physicians WHICVH DOES NOT CURRENTLY EXIST in our practice and is extremely limited, even for fully funded patients, in our community
3. We will ensure timely access to an ophthalmologist. We cannot determine a baseline at this point because there are no ophthalmologists in our practice. We will establish a baseline for this in DY2 and reduce the time by 20% in DY3 and by 40% in DY5 compared to DY3.

Category 3 outcomes: The total number of Hispanic patients with a diagnosis of diabetes who receives a screening eye exam will increase 25% in DY 4 and 40% in DY 5 over baseline in DY3.

The number of Hispanic patients reporting a satisfaction score of 80 or higher will improve 10% each year in DY4 and DY5 or be greater than 70% in DY4 and 75% in DY5.

The time taken to see a performing provider ophthalmologist from referral from a performing provider therapeutic optometrist among Hispanic patients with diabetes will be reduced 20% in DY4 and 40% in DY5 compared to baseline in DY3.

New initiative or enhancement /expansion of an existing initiative: This is a new initiative.

Project Description:

The purpose of this project is to address the Region's inability to meet the ocular care needs of its patients, particularly the indigent and Medicaid populations, due to profound shortage of ocular care professionals in the Region. The project proposes to address this issue by the recruitment of four additional ocular care providers (two ophthalmologists and two additional therapeutic optometrists) along with the required support personnel, and the development an electronic referral system linking primary care to the ophthalmology providers to facilitate referrals.

Goals and Relationship to Regional Goals:

The goal of this project is increase access for ocular care, in particular for patients with diabetes, to low income, indigent and Medicaid populations. Patients will receive adequate ocular care and will no longer experience long waiting periods for appointments. Comprehensive ocular care, including evaluation by an ophthalmologist, will be available in a timely manner. Finally, we will develop electronic means of communicating referral requests to facilitate access from our primary care providers.

Project Goals:

- Increase number of ocular specialists in the region by four
- Create efficiencies through the use of an electronic referral system.

Challenges: The major challenge we will face is to identify and recruit the numbers of providers required to meet the needs of our community.

This project meets a number of regional goals: It will allow us to better provide the full continuum of healthcare services, from wellness to preventative care to disease management; to better manage patients with chronic diseases, such as Diabetes; and to Increase the number of specialist and scope of services offered in the community; to increase patient satisfaction through delivery of high-quality, effective healthcare services and to address issues related to diabetes as it represents a major health concern in Region 15.

DY5 Expected Outcome for Provider and Patient:

At the completion of this project, we will be able to provide nearly comprehensive ocular care to our population. We anticipate measuring and significantly improving our organization's referral of patients with diabetes for annual eye exams as recommended by HEDIS guidelines. We expect to see increased patient numbers in our ophthalmology program, particularly those with diabetes, and we will have a functional, widely utilized, electronic referral system.

We anticipate DY2 to be a year of planning and recruitment, and confirming the number of unique patients seen annually which we estimate to be 1000. The number of unique patients estimated to be seen by DY is
DY2:1000 DY3:1250 DY4:1500 DY5:1800

The number of patients does not increase linearly with the number of providers because as we add additional providers, we will be providing more complex services than are currently available to this population.

Starting Point and Baseline:

The majority of the region's ophthalmologic care resides in the private community. Ophthalmologic care provided by the Paul L. Foster School of Medicine is profoundly limited. The School of Medicine employs a single therapeutic optometrist, housed within the Department of Surgery. **The current time to 3rd available appointment for new patients for this provider is 59 days.** We have no ophthalmologists available to provide routine outpatient screening and treatment services.

Rationale:

Ophthalmology care in Region 15 is in a state of crisis. A 2010 health needs assessment, sponsored by the Paso del Norte Foundation, which serves as the basis of our RHP, documented that the area is underserved in 18 of the 24 assessed specialties and ophthalmology was the fourth greatest numerical need. This needs assessment indicated that Region 15 was underserved by nearly 24 ophthalmologists[i].

A significant proportion of our 1115 DSRIP waiver projects are focused on access issues and lack of providers in our region as documented in the Region's needs assessment i and the impact of these shortages on chronic diseases such as diabetes. In the case of ocular services, this shortage creates serious challenges, particularly for our unfunded and Medicaid patient population. We have difficulty in identifying a provider who will accept a patient requiring therapeutic services which can only be supplied by an ophthalmologist. We have no ability to treat common conditions such as macular degeneration or keratoconus because of the time required in the fitting of hard contact lenses and the extremely limited provider availability. We also have extremely limited access to ophthalmologic specialties which are commonly required in a diabetic population such as retinal specialists.

Even for patients with adequate funding, accessing ophthalmologic care in our region is challenging. Data from one of our major Medicare plans indicates compliance with HEDIS guidelines for screening eye care in the region is poor; less than 50% of patients with diabetes receive an annual eye exam and only 61% of patients at risk of glaucoma have received an evaluation. We fully anticipate that compliance rates in our indigent population will be significantly below these levels, and part of our Category 3 initiatives are to develop the benchmarking strategies to be able to track this number.

The issue of appropriate ocular screening and treatment is of particular importance to our population given the high prevalence of diabetes in the region and the large numbers of patients at risk for diabetes. Diabetes is a particular health care challenge in Region 15 and in particular in our population. Diabetes is the fourth leading cause of blindness in adults and early diagnosis of diabetic retinopathy can prevent blindness.[ii] The self-reported rate of diabetes in El Paso is 12.8%, compared to a nationwide self-reported rate of 9.3%. This becomes even more significant as the population ages. The self-reported rate of diabetes in El Paso increases from 6.4 % when less than 45 years of age to 19.1 % for ages 45 to 64 and to 28.5% for ages 65 and older. Over 70% of El Paso residents are of Hispanic ethnicity, an additional risk factor for diabetes. Therefore, most of the population is at risk for diabetes.

In addition to a high prevalence of diabetes, our population has significant access challenges based on their insurance program, or lack of 3rd party coverage. 37.1% of BRFSS respondents from El Paso report no health insurance, compared to a nationwide rate of 15.1%. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. When considering only our existing optometrist, this number increases to over 80% of patients with Medicaid or no insurance. With extremely limited resources in the private community, and the current wait times for a new patient appointment in our system now, there is simply no potential to improve the overall access issue, and address long term risks of blindness from diabetes and other chronic diseases without a significant expansion of provider resources.

Our general approach reflects the opportunity to use a variety of eye care professionals to provide comprehensive care in a cost effective manner. As an example, a therapeutic optometrist is an excellent resource for screening and diagnosis of ocular disease. They may provide limited non operative treatment services, such as for glaucoma, if they possess the appropriate additional certification. They are not able to provide any operative treatments, such as laser management of diabetic retinopathy. The region has very little capability to support unfunded or Medicaid operative ocular services including cataract services or therapy (as opposed to diagnosis) of hypertensive or diabetic related eye diseases. Therefore, we include the recruitment of ophthalmologists in this proposal.

We chose the Option 1.9.3 because the limiting factor in providing care is not space, and we are not in a position to expand or even establish a training program at this point. Furthermore additional clinic hours or locations are feasible with a single provider. By selecting Option 1.9.3, we are focusing on the core issue of an inadequate number of providers to serve this patient population in the region, and on means to insure they are utilized most effectively.

We have chosen metrics which reflect three main outcome objectives of this project:

- increasing availability of providers to improve access a
- measure and improve the speed of access to an ophthalmologist once an issue is identified by a therapeutic optometrist.

- Develop and implement an electronic referral system which addresses the unique needs of an ophthalmology practice linking primary and specialty care

We begin by generating baseline data of the number of unique patients seen each year, and the time to be seen by an ophthalmologist after referral by a therapeutic optometrist. Collectively, these metrics represent a comprehensive view of the goal of this project which is to improve access to ocular care for our at risk population. We also begin the planning, design and implementation for an e-referral system linking primary care to ophthalmology

This represents a new initiative for the Performing provider.

This project addresses CN.2, access to secondary / specialty care.

Related Category 3 Outcome Measure(s):

IT-11.3 Improve utilization rates of clinical preventive services (diabetic eye exams) in Hispanic population with identified disparity. We will use language identical to IT-12 limited to those patients who self-report ethnicity or race as Hispanic

This Category 3 outcome measure was chosen based on the rationale that the primary issue we are addressing with this project is the lack of access to comprehensive ocular care for underserved patients in Region 15, and that the majority of our patients are of Hispanic origin and uninsured or underinsured with a high prevalence of diabetes. As such, increases in the number of unique patients screened for diabetic eye disease is an important marker of the impact this program is having in this population.

By focusing on the number of patients screened, and having resources to treat those we identify with disease, we provide evidence based processes to impact the long term effects of diabetes, cataracts, macular degeneration, and other ocular diseases.

IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. We propose to utilize the RAND VSQ-9 Patient Satisfaction Survey to measure patient satisfaction. The Performing Provider has experience with Press Ganey survey instruments within the past decade. Overall response rates were very low, in the single digit range. We believe there are a series of structural issues that drove this poor response. Our population is heavily enriched in low income patients. Challenges related to incorrect and changing addresses, and the comprehension level required to complete more complex survey tools such as Press Ganey (and CG-CAHPS) limits response rates. Also, our Region shares an international border with Juarez, Mexico. Many patients, whether documented or not, may fear responding to such a survey, not fully understanding the importance of their response, and not recognizing that their participation has no impact on their residence in the Region, choose not to respond.

For these reasons we believe a short survey, administered at the point of service, represents the best option to obtain meaningful data across a wide patient representation. The RAND survey has been validated for accuracy and validity [iii] and contains questions which focus on high level patient satisfaction domains and will provide actionable information to improve our regional care delivery. We acknowledge that this survey will not provide results which are directly comparable to CG-CAHPS on a national level. They will, however, provide valid, actionable data on which to assess the impact of this project in Region 15.

11.6 Other Outcome Improvement Target: We propose to measure the time taken to see a performing provider ophthalmologist from referral from a performing provider therapeutic optometrist among Hispanic patients with diabetes. The time taken to see a performing provider ophthalmologist from referral from a performing provider therapeutic optometrist among Hispanic patients with diabetes will be reduced 20% in DY4 and 40% in DY5 compared to baseline in DY3

Screening services provide little benefit if not coupled to diagnosis and treatment of conditions identified. Given the shortage of ophthalmologists in the region, and the significant burden of indigent and Medicaid patients in our population, this access likely represents a significant healthcare disparity. By tracking this, we are able to couple effective screening with diagnosis and therapy for diabetic eye disease among Hispanics.

Relationship to Other Projects:

1) 084597603.1.2: The establishment of a disease management registry within the Paul L. Foster School of Medicine. This project will initially focus on diabetes in the Department of Family Medicine, and subsequently, capture the diabetic population cared for by general internists in the Department of Internal Medicine. The screening of patients with diabetes is one of the fundamental objectives of this project. Use of the registry will facilitate the appropriate identification of these individuals.

2) 084597603.2.1. The Development of a Primary Care Medical Home in a Health Professions Shortage Area. The PCMH in the Department of Family Medicine represents an excellent target population to enable identification, tracking and referral of at risk individuals

Relationship to Other Providers' Projects in the RHP: Other performing providers in the Region are proposing significant expansions of access to primary care. Undoubtedly, this will involve large numbers of patients with diabetes. Our project provides the mechanism in which these patients can receive the specialized screenings necessary and access to diagnosis and treatment as required.

Plan for Learning Collaborative: We will participate in a minimum of semi-annual learning collaborative sponsored by the RHP, and provide data on the status of our project.

Valuation:
The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the

waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

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[i] Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

[ii] http://www.nei.nih.gov/nehep/research/The_Eye_Health_needs_of_Older_Adults_Literature_Review.pdf. Accessed October 1, 2012.

[iii] http://www.rand.org/health/surveys_tools/vsq9.html. Accessed September 29, 2011

084597603.1.1	***1.9.3***	***PROJECT COMPONENTS 1.9.3 (A-D)***	A Proposal to Increase Access to ocular care to an Underserved Population
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 3 Outcome Measure(s):	084597603.3.2 084597603.3.3 084597603.3.1	*IT-11.4* *IT-11.3* *IT-11.6*	Improve patient satisfaction Improve utilization rates of clinical preventive services 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-X-2 Design and develop the capacity to monitor and report on the number of unique patients seen in the PP ophthalmology program. This is in support of Improvement target I-23 in DY3-5. Metric: Conduct needs assessment, engage stakeholders, identify resources, determine timelines, and document implementation plans Data Source: EMR, Electronic scheduling system Milestone 1 Estimated Incentive Payment: $427,500 **Milestone 2** [P-7]: Complete a planning process/submit a plan to implement electronic referral technology Metric 1 [P-7.2]: Develop a staffing plan for referral system	**Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-1.23.2]: Documentation of increased number of visits. Demonstrate 25% improvement over DY2 baseline Goal: Performing provider will be 1250 unique patients (a 25% increase from estimated baseline in DY2) - Data Source: EMR, Electronic Scheduling systems Milestone 5 Estimated Incentive Payment $375,559.80 **Milestone 6** [P-7]: Complete a planning process/submit a plan to implement electronic referral technology	**Milestone 10** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-1.23.2]: Documentation of increased number of visits. Goal: Performing provider will provide services to 1500 unique patients Data Source: EMR, Electronic Scheduling systems Milestone 10 Estimated Incentive Payment *(maximum amount):* $ $1,004,400 **Milestone 11** [P-9]: Implement referral technology and processes that enable improved and more streamlined provider communications Metric 1 [P-9.1]: Documentation	**Milestone 12** [I-33]: Increase specialty care capacity using innovative project option. Metric 1 [I-1.33.3]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over DY3 The number of unique patients seen Goal: Performing provider will provide services to 1800 unique patients Data Source: EMR, Electronic Scheduling systems Milestone 12 Estimated Incentive Payment *(maximum amount):* $970,435 **Milestone 13 [P-10]**: Increase referral coordination resources for primary care and medical specialty clinics by developing and implementing bi-directional

084597603.1.1	***1.9.3***	***PROJECT COMPONENTS 1.9.3 (A-D)***	A Proposal to Increase Access to ocular care to an Underserved Population
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 3 Outcome Measure(s):	084597603.3.2 084597603.3.3 084597603.3.1	*IT-11.4* *IT-11.3* *IT-11.6*	Improve patient satisfaction Improve utilization rates of clinical preventive services 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)**
Goal: Documentation of implementation plan including description of staff and training required, hardware and software needs, and implementation timeframe to establish e-referral functionality from primary care providers to ophthalmology providers. Data Source: implementation plan Milestone 2 Estimated Incentive Payment:$427,500 **Milestone 3: [I-22]** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric [1-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in	Metric 1 [P-7.1] Complete a staffing plan for the implementation of e-referral to ophthalmology. Data Source: Project plan Milestone 6 Estimated Incentive Payment: $375,559.80 **Milestone 7** [P-8]: Develop the technical capabilities to facilitate electronic referral Metric 1 [P-8.1]: Demonstrate technical mechanisms to be used to operate referral system are in place Goal: recruit / assign IT and / or EMR team members to support the roll-out of e-referral as described in the implementation plan developed in Milestone 4 Data Source: Project plan Milestone 7 Estimated Incentive	of referrals technology Goal: Implement e-referral technology Data Source: IT documentation of "go-live" of e-referrals technology and referrals reports. Milestone 11 Estimated Incentive Payment : $1,004,400	communication functionality in the system Metric 1 [P-10.1]: Number of primary care and medical specialty clinics that manage referrals utilizing the bi-directional communication function of the referral management system to ophthalmology. Goal: The number of referrals received electronically will increase by 50% from DY4 Data Source: referral management system Milestone 12 Estimated Incentive Payment *(maximum amount):* $970,435

084597603.1.1	***1.9.3***	***PROJECT COMPONENTS 1.9.3 (A-D)***	A Proposal to Increase Access to ocular care to an Underserved Population	
TEXAS TECH HS CTR FAMILY MED				TPI 084597603
Related Category 3 Outcome Measure(s):	084597603.3.2 084597603.3.3 084597603.3.1	*IT-11.4* *IT-11.3* *IT-11.6*	Improve patient satisfaction Improve utilization rates of clinical preventive services 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)**
targeted specialties Goal: Performing provider will increase the number of ocular care professionals (Ophthalmologists and / or therapeutic optometrists) by two Data Source: HR records showing hiring in DY2. Milestone 3 Estimated Incentive Payment:$427,500 **Milestone 4: [P-21]:** Participate in face-to-face meetings twice a year with other providers to promote similar projects. Each meeting will allow stakeholders to agree upon improvement areas. <u>Metric [P-21.1]:</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP Data sources: Attendance records	Payment $375,559.80 **Milestone 8: [I-22]** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric [1-22.1] Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Performing provider will increase the number of ocular care professionals (Ophthalmologists and / or therapeutic optometrists) by two Data Source: HR records showing hiring in DY3. Milestone 8 Estimated Incentive Payment: $375,559.80		

084597603.1.1	***1.9.3***	***PROJECT COMPONENTS 1.9.3 (A-D)***	A Proposal to Increase Access to ocular care to an Underserved Population	
TEXAS TECH HS CTR FAMILY MED				TPI 084597603
Related Category 3 Outcome Measure(s):	084597603.3.2 084597603.3.3 084597603.3.1	*IT-11.4* *IT-11.3* *IT-11.6*	Improve patient satisfaction Improve utilization rates of clinical preventive services 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)**
of semi-annual meetings, copies of presentations to meeting. Milestone 4 Estimated Incentive Payment:$427,500	**Milestone 9: [P-21]** Participate in face-to-face meetings twice a year with other providers to promote similar projects. Each meeting will allow stakeholders to agree upon improvement areas. Metric [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Data sources: Attendance records of semi-annual meetings, copies of presentations to meeting. Milestone 9 Estimated Incentive Payment: $375,559.80			
Year 2 Estimated Milestone Bundle Amount: $1,710,00	Year 3 Estimated Milestone Bundle Amount: $1,877,790		Year 4 Estimated Milestone Bundle Amount: $2,008,800	Year 5 Estimated Milestone Bundle Amount: $1,940,870
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $7,537,460				

95696

Project Option 1.3.1: A proposal to establish an enterprise wide Chronic Disease Management Registry

Unique Project ID: 084597603.1.2

Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / TPI 084597603
Project Title: Establish an enterprise wide Chronic Disease Management Registry

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: The project will establish an enterprise wide disease management capability with the ability to support multiple diseases and conditions, available to all clinical departments in our organization.

Need for the project: There is no formal registry functionality in the performing providers practice. This capability will be essential to support formal designation as a medical home, and to efficiently meet HEDIS and other quality markers in the Medicaid and unfunded populations.

Target Population: The target population for this infrastructure development includes patients with a host of chronic diseases, most urgently diabetes and breast cancer. Given that 60% of our ambulatory encounters are to patients with Medicaid or no insurance, this project will be a direct benefit to that population.

Category 1 or 2 expected benefits : We will establish registry functionality to enroll patients with Diabetes or Breast Cancer. We will use this registry to provide dietary training to a minimum of 20% of the patients with a diagnosis of diabetes. We will establish registries for patients with Diabetes in the Departments of Family Medicine and Internal Medicine, and for patients with breast cancer in the Department of Internal Medicine. We estimate there are approximately 2000 patients with diabetes in the Kenworthy Family Medicine clinic with diabetes that routinely use that location as their primary care. DY2 will be preparation, software evaluation and installation and training. We will enroll the following numbers of patients with diabetes in the registry:

DY2: 0 DY3: 1000 DY4:1300 DY5:1500

Category 3 outcomes: a minimum of 55% of the patients with diabetes cared for by our Family Medicine clinic will achieve compliance with Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061. This represents an estimated 825 unique patients

New initiative or enhancement /expansion of an existing initiative: This is a new initiative.

Project Description:

The intent of this project is to develop the resources and infrastructure to design, build, and maintain patient registries as an enterprise priority available as a resource to support any Department that

identifies a need. By developing these resources centrally, we can be assured that disease conditions treated by multiple departments are recorded in a uniform manner for comparison and reporting

The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. The School is in the process of implementing an EMR and all primary care Departments are currently utilizing this integrated enterprise system, with the enterprise completely on-line by the end of DY2. Paul L. Foster School of Medicine is the largest provider of ambulatory care to the uninsured and Medicaid populations in the region. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance.

Relationship to Regional Goals: This project addresses the Region's goal to better manage patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, and Renal disease to help prevent unnecessary readmission. The first condition we propose to enroll in the registry is diabetes, one of reflecting the disproportionate burden this disease places on our Region's patients as indicated by its specific inclusion among our regional goals.

Challenges: Like other under-resourced public institutions, PLFSOM has poorly developed internal communication structures within its clinical care delivery system. Divisions between the silos of administration, nursing, support services, and medical staff have resulted in a multiplicity of parallel and typically under-resourced or under-utilized responses to the need to gather registry level information. Historically, these efforts were led by single providers with a passion for the program, and were either unsustainable or collapsed when the founder moved on.

Project Goals:

- To establish, at an enterprise level, the resources to develop, implement and maintain disease management registry programs, to support primary and specialty care clinics.

- To establish active patient registries in at least two conditions which reflect its use in primary versus specialty care, and across departments in the organization.

Expected 5-year outcome for providers and patients: By the end of DY5, PLFSOM will have implemented disease management registries in Internal Medicine and Family Medicine for diabetes and breast cancer. These conditions were chosen based on 1) high prevalence and impact in our population 2) the desire to implement this functionality in multiple clinics and departments encompassing primary and specialty care 3) the need to provide a means to link the patient in both primary and specialty care, and 4) because these conditions represent well documented opportunities to improve access and reflect organizational priorities for other 1115 wavier projects

Baseline: We have no formal registry functionality on campus at this point. There are several small databases of patients with specific conditions, but these are essentially just lists of patients; they do not include any of the functionality commonly associated with robust registry programs.

We estimate there are approximately 2000 patients with diabetes in the Kenworthy Family Medicine clinic with diabetes that routinely use that location as their primary care. DY2 will be preparation,

software evaluation and installation and training. We will enroll the following numbers of patients with diabetes in the registry:

DY2: 0 DY3: 1000 DY4:1300 DY5:1500

Rationale: Our population caries a disproportionate burden of chronic diseases. The BRFSS 2010 self-reported rate of overweight and obesity, risk factors for diabetes, in PHA Region 9/10 is 67.5 %, while the nationwide rate is 64.3. Over 70% of El Paso residents are of Hispanic ethnicity, an additional risk factor for diabetes. Therefore, most of the population is at risk for diabetes. Indeed, the self-reported rate of diabetes in El Paso is 12.8%, compared to a nationwide self-reported rate of 9.3%. This becomes even more significant as the population ages. The self-reported rate of diabetes in El Paso increases from 6.4 % when less than 45 years of age to 19.1 % for ages 45 to 64 and to 28.5% for ages 65 and older. The overall impact of this particular chronic disease is huge, and 37.1% of BRFSS respondents from El Paso report no health insurance, compared to a nationwide rate of 15.1%.

Diabetes is the third leading cause of death in the border region of US-Mexico (Healthy Borders 2010, The United States-Mexico Border Health Commission). In addition to mortality, diabetes morbidity is a significant problem. In the border region, the incidence rate for diabetes was 310.9 per 100,000 inhabitants in 1995, and by the year 2000 this rate had grown by 35.5 percent. The hospitalization rate (discharges per 100,000 population) in 2000 for diabetes was 14.9 for the region leading to significant health costs.

The population served by PLFSOM is particularly at risk. Approximately 70% of our patient base lack 3rd party insurance coverage or have only Medicaid. **Our region has a profound shortage of adult primary care physicians, estimated at nearly 370**[i]. Given this profound shortage, it is very difficult for unfunded or underfunded patients to access primary care for chronic conditions, and absolutely critical that, as an organization, we have in place the tools to be able to identify, track and proactively manage chronic diseases on a population level. A registry is essential to accomplish this goal.

If care as currently practiced for the chronic disease conditions were optimized for Medicaid and unfunded patients, then patients with diabetes, for example, would be identified and treated effectively reducing both the mortality rate of diabetes and the need for hospitalization. However, we know that a substantial proportion of high risk patients have suboptimal outcomes for managing and improving outcomes for chronic disease. This disparity may be addressed, in part, through programs which track clinically relevant information in a uniform manner and deliver to the provider at the point of care.
Cancer is the second leading cause of death in the border regions of Mexico and the United States[ii]. Each year, more than 13,000 border residents die from cancer, with about 3,000 deaths in Mexico and more than 10,000 in the United States border area. The 2000 mortality rate for malignant neoplasms in the Mexico border region was 59.0 per 100,000 inhabitants and 174.4 in the U.S. border region.

The most important cancer sites or types, in terms of cancer mortality, are lung cancer, stomach and colorectal cancer, breast cancer, and cervical and prostate cancers. Survival rates for most cancers are significantly improved through early detection and treatment. Improved screening for cancer is essential to reduce the cancer death rate programs which track clinically relevant information and deliver to the provider at the point of care would have significant impact. Female breast cancer is one of the most important cancers for border women. In the United States, the diagnosis of new cases of breast cancer is increasing among Hispanics.

We chose Project Option 1.3.1 because we have no organized or functional enterprise or Departmental level registry program or resources and we will accomplish all required elements in this option set.

a) Enter patient data into unique chronic disease registry. This will accomplished in late DY2 and DY3 as the registry function is rolled out, and is a formal Improvement target (IT-15) in DY4 and DY5.
b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need. This is included in P-5 in DY3.
c) Use registry reports to develop and implement targeted QI plan. P-13 is included in DY3, DY4 and DY5 in the clinical setting and includes review of data and formulating responses including identifying improvements needed
d) Conduct quality improvement for project. P-13 is included in al l4 DY years and reflects ongoing, weekly analysis of information from the registry and formulating responses to the data.

We propose to incorporate the continuous quality improvement requirements initially by including Registry status as a standing item on our EMR steering committee agenda. This committee consists of senior administration (Associate Deans for finance and clinical affairs, VP of Information Technology, EMR project manager, Medical Records and Quality Directors), can pull in ad hoc representatives from the scheduling system group, and reports directly to the Dean of the Medical, the senior most leader of the Performing Provider. This group meets at least bi-weekly and usually weekly. Once the Registry is in operation, we will have regular meetings with clinic personnel to review.

This project addresses: CN.1 expansion of Primary care and CN.2 access to specialty / secondary care.

The improvement milestones reflect the adoption of the registry by end users and the expansion of this functionality to other Departments and providers, reflecting one of the core goals of this project, namely to establish and maintain this functionality at an enterprise, rather than local level.

As noted above, we have no registry capability at this point. This is a significant, new initiative for us.

The milestones chosen for this project reflect the planning and IT / EMR integration required to fully optimize the use of the registry, reflecting the current state of readiness of the Kenworthy Family Medicine Clinic where we will initially role it out. Our improvement targets reflect the goal of expanding this registry functionality across departments and to specialty as well as primary care conditions.

Improved care of DM patients by utilization of registries will lead to better patient outcomes from better data available to providers, fewer complications needing secondary and tertiary care from specialists in both inpatient and outpatient settings and based on data from THE PATIENT CENTERED PRIMARY CARE COLLABORATIVE, a reduction in hospital admissions. http://www.pcpcc.net/
The utilization of a registry for patients with breast cancer supports long term sequential follow up of this high risk group, which is essential in managing the two year survivorship program proposed in another of our projects.

Related Category 3 Outcome Measures:

IT-1.11 Diabetes care: *BP control*

Establishment of a registry in and of itself is of little utility in the care of patients with chronic disease. Its value is demonstrated by being able to identify populations of patients and then manage them based on nationally accepted, evidence based, processes. The Improvement milestones selected represent a common core care issues for patient with diabetes, which aligns with the patient population we intend to track initially with this registry. Demonstrating improvement in these care parameters through use of the registry will conclusively demonstrate the value of this effort.

Relationship to Other Projects: Registry functionality is related to:

084597603.1.1 Expansion of Specialty Care in Ophthalmology and

084597603.1.4 Expansion of Breast Care Services to an Indigent and Underserved Population.

To most fully recognize the benefits of a registry system, it is essential that the resources for meeting the healthcare needs identified through the registry are available. Improving ocular care for patients with diabetes care requires a significant increase in ocular care professionals as we have proposed, and impacting the status of women with breast disease requires access to diagnosis and treatment of conditions identified. Our Expansion of Breast Care Services represents an effort to meet this need.

Relationship to Other Providers' Projects in the RHP: University Medical Center is significantly increasing their primary care capabilities through neighborhood health centers and has a project to develop the PCMH model in these clinics. We will share 'lessons learned' in the transition to a medical home with all RHP participants.

Plan for Learning Collaborative: The performing provider will participate in semi-annual RHP meetings sharing knowledge learned from this effort.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit. Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

[i] Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

[ii] http://www.borderhealth.org/files/res_63.pdf. Accessed 10/14/2012

084597603.1.2	***1.3.1***	***PROJECT COMPONENTS: 1.3.1 (A-D)***	A proposal to establish an enterprise wide Chronic Disease Management Registry.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.4	*IT-1.11*	*Diabetes Care: BP control*

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] Review current registry capability and assess future needs. Metric2.1: Documentation of review of current registry capability and assessment of future registry needs. Goal: The Performing Provider will establish a multi-disciplinary team to assess current registry capabilities and assess future needs Data Source: Committee report Milestone 1 Estimated Incentive Payment *(maximum amount):* $ $266,666 **Milestone 2** [*P-3*]: Develop cross-functional team to evaluate registry program Metric 1 [P-2.1]: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program. Goal: The Performing Provider will establish a multi-functional team that is charged with evaluation, implementation and maintenance of the registry program. Data Source: Team roster, meeting minutes	**Milestone 4** [P-6]: Conduct staff training on populating and using registry functions. Metric 1 [P-6.1]: Documentation of training programs and list of staff members trained, or other similar documentation. Goal: 90% of providers and clinical staff in the Kenworthy Family Medicine Clinic will be trained on registry functionality and usage. Data Source: Attendance records. Milestone 4 Estimated Incentive Payment *(maximum amount):* $ $146,416 **Milestone 5** [P-4]: Implement / expand a functional Disease Management Registry Metric 1 [P-4.1]: Registry functionality is available in the Department of Family Medicine Kenworthy Clinic and targets patients with Diabetes Goal: Registry functionality is available in 100% of the Department of Family Medicine Clinical sites. Data Source: IT documentation of installation, and training on registry	**Milestone 10** [P-6]: Conduct staff training on populating and using registry functions. Metric 1 [P-6.1]: Documentation of training programs and list of staff members trained, or other similar documentation. Goal: 90% of primary care and oncology providers and clinical staff in the Internal Medicine General Medicine Clinic and Oncology group will be trained on registry functionality and usage. Data Source: Attendance records. Milestone 10 Estimated Incentive Payment *(maximum amount):* $134,256 **Milestone 11** [I-19]: Spread registry functionality throughout Performing Provider facilities Metric 1 [I-19.1]: Increase the number of clinics/sites associated with the Performing provider's facility that are providing continuity of care for the defined population using the disease management registry functionality. Goal: Registry functionality is available in two additional clinics	**Milestone 17** [I-15]: Increase the percentage of patients enrolled in the registry. Metric 1 [I-15.1]:: Percentage of patients in the registry Goal: 75% of patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes will be entered in the registry. We estimate this to be 1500 unique patients Data Source: EMR, Registry Milestone 17 Estimated Incentive Payment *(maximum amount):* $454,004 **Milestone 18 [**P-13]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions. Metric 1 [P-13.1]: Number of new ideas, practices, tools or solutions Goal: The Department of Internal medicine and Kenworthy Family Medicine will review weekly registry functionality and evaluate user feedback to general new ideas, practices, tools or solutions.

084597603.1.2	***1.3.1***	***PROJECT COMPONENTS: 1.3.1 (A-D)***	A proposal to establish an enterprise wide Chronic Disease Management Registry.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.4	*IT-1.11*	*Diabetes Care: BP control*

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)**
Milestone2 Estimated Incentive Payment *(maximum amount):* $266,666 **Milestone 3** [P-13]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions. <u>Metric 1</u> [P-13.1]: Number of new ideas, practices, tools or solutions. Goal: Kenworthy Family Medicine Clinic will establish a reoccurring agenda item in their weekly department meeting to solicit and review new ideas, solutions, and practices. Data Source: quarterly summaries of ideas presented and solutions tested. Milestone 3 Estimated Incentive Payment *(maximum amount):* $266,666	functionality. Milestone 5 Estimated Incentive Payment: $146,416 **Milestone 6** [P-5]: Demonstrate registry automated reporting ability Metric 1 [P-5.1]: Documentation of registry automated report Goal: 50% of patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes will be entered in the registry. We estimate this to be 1000 unique patients Data Source: EMR, Registry Milestone 6 Estimated Incentive Payment: $146,416 **Milestone 7** [P-7]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps and reducing preventable acute care. Metric 1 [P-7.1]: Implement and document results of test plan Goal: The Performing Provider will develop, and implement a testing plan to assess the accuracy of the registry with respect to the diagnosis of diabetes, and to determine how frequently data from the registry	within one additional Department. Data Source: IT documentation of installation, and training on registry functionality, Registry reports Milestone 11 Estimated Incentive Payment *(maximum amount):* $134,256 **Milestone 12** [P-13]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions. <u>Metric 1</u> [P-13.1]: Number of new ideas, practices, tools or solutions. Goal: The Department of Internal medicine will review weekly registry functionality and evaluate user feedback to general new ideas, practices, tools or solutions. Data Source: quarterly summaries of ideas presented and solutions tested. Milestone 12 Estimated Incentive Payment *(maximum amount):* $134,255 **Milestone 13** [P-10] Implement a cross-functional team to staff registry	Data Source: quarterly summaries of ideas presented and solutions tested. Milestone 18 Estimated Incentive Payment *(maximum amount):* $454,004

084597603.1.2	***1.3.1***	***PROJECT COMPONENTS: 1.3.1 (A-D)***	A proposal to establish an enterprise wide Chronic Disease Management Registry.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.4	*IT-1.11*	*Diabetes Care: BP control*

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)**
	impact patient care Data Source: test plan and results reports Milestone 7 Estimated Incentive Payment *(maximum amount):* $146,416 **Milestone 8** [P-10]: Implement a cross-functional team to staff registry program. Metric 1 [P-10.1]: Documentation of personnel (clinical, IT, administrative) assigned to staff registry program. Goal: The Performing Provider will identify and deploy a cross-function team supporting the Department of family Medicine to staff the registry in that Department. Data Source: Personnel assignment records Milestone 8 Estimated Incentive Payment *(maximum amount):* $146,416 **Milestone 9** [P-13 Review project data and respond to it every week with tests of new ideas, practices, tools or solutions.	program. Metric 1 [P-10.1]: Documentation of personnel (clinical, IT, administrative) assigned to staff registry program. Goal: The Performing Provider will identify and deploy a cross-function team supporting the Department of Internal Medicine to staff the registry in that Department. Data Source: Personnel assignment records Milestone 13 Estimated Incentive Payment *(maximum amount):* $134,255 **Milestone 14** [I-15]: Increase the percentage of patients enrolled in the registry. Metric 1 [I-15.1]: : Percentage of patients in the registry Goal: 65% of patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes will be entered in the registry. We estimate this to be 1300 unique patients Data Source: EMR, Registry Milestone 14 Estimated Incentive Payment *(maximum amount):* $134,255	

084597603.1.2	***1.3.1***	***PROJECT COMPONENTS: 1.3.1 (A-D)***	A proposal to establish an enterprise wide Chronic Disease Management Registry.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.4	*IT-1.11*	*Diabetes Care: BP control*

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 1 [P-13.1]: Number of new ideas, practices, tools or solutions. Goal: Kenworthy Family Medicine Clinic will establish a reoccurring agenda item in their weekly department meeting to solicit and review new ideas, solutions, and practices. Data Source: quarterly summaries of ideas presented and solutions tested. Milestone 9 Estimated Incentive Payment *(maximum amount):* $146,416	**Milestone 15** [P-7]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps and reducing preventable acute care. Metric 1 [P-7.1]: Implement and document results of test plan Goal: The Performing Provider will develop, and implement a testing plan to assess the accuracy of the registry with respect to the diagnosis of breast cancer, and to determine how frequently data from the registry impact patient care Data Source: test plan and results reports Milestone 15 Estimated Incentive Payment *(maximum amount):* $134,255 **Milestone 16:**[I-17]: Use the registry to identify patients and families that would benefit from targeted patient education services. Metric 1 [I-17.3]: Establishment of training programs developed and conducted by clinicians. Goal: 20% of patients with a diagnosis of diabetes maintained in	

084597603.1.2	***1.3.1***	***PROJECT COMPONENTS: 1.3.1 (A-D)***	A proposal to establish an enterprise wide Chronic Disease Management Registry.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.4	*IT-1.11*	*Diabetes Care: BP control*

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 registry at Family Medicine clinics will have received group dietary training in DY4 Data Source: test plan and results reports Milestone 16 Estimated Incentive Payment *(maximum amount):* $134,255	
Year 2 Estimated Milestone Bundle Amount$799,998	Year 3 Estimated Milestone Bundle Amount: $878,496	Year 4 Estimated Milestone Bundle Amount: $939,785	Year 5 Estimated Milestone Bundle Amount: $908,008
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,526,287			

95673

Project Option: 1.9.3: A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network

Unique Project Identifier: 084597603.1.3
RHP Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603
Project Title: A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will three interventions: 1) recruit a significant cohort of physician and non-physician neurology providers to address the immediate access issues; 2) establish two additional geographically distinct ambulatory neurology care sites 3) hire and deploy the necessary technicians and support staff to provide EMG and EEG services in the outpatient setting and 4)establish a neurology residency program as a long term solution to a significant neurology provider shortage in the region.

Need for the project: Neurology has been identified as one of the 5 greatest provider needs in our Region. The performing provider has a single neurologist on faculty and the current time to 3rd available new appointment for this provider is 179 days**.** Wait times in the community range to 60 days for a limited number of providers who are accepting new patients. The region is underserved by a least 12 providers, and of the 10 neurologist in El Paso, 5 are nearing the end of their clinical careers. Multiple attempts by the private sector as well as the performing provider in recent years to recruit neurologists have been unsuccessful. Included in the Appendix to this project are multiple letters of support from private and military neurologists in our region, confirming the critical need for these services in our region

Target Population:
a) Number of patients served: Given the extreme provider shortages, it is impossible to predict unmet need for services. However we anticipate serving a minimum of 300 unique patients each year in each of two additional ambulatory sites.

b) Benefit to Medicaid / Indigent Patients: Given that 60% of our ambulatory encounters are to patients with Medicaid or no insurance, this project will be a direct benefit to that population.

Category 1 or 2 expected benefits: We will increase the number of neurology providers from the current one to 10. We will establish a neurology residency program , establish at two additional, geographically distinct clinical sites for neurology services seeing a minimum of 300 unique new patients at these location, and increase the number of unique patients seen in the entire program by 25% in DY3, DY4 and DY5.

We estimate that the Department of Neurology currently sees approximately 400 unique patients per year and these are primarily general neurology patients. Based on anticipated timing of CMS project

approval, and recruitment lag times, the number of unique patients in DY2 will be about 600. In DY 3-5, this will increase by 25% each year. The number of unique patients served is estimated at
DY2: 600 DY3: 750 DY4: 940 DY5: 1170

The patient volume does not linearly track the number of new providers for two reasons: 1) an essential element to address, in a long term sustainable fashion, the critical shortage of neurology providers is to establish a neurology residency program. This requires a significant commitment of physician resources in the planning, curriculum development and documentation areas which do not result in direct patient care and 2) the current patient mix is largely general neurology. An essential element of this project is to recruit a wide range of neurology subspecialists. The patients seen in these clinics are likely to be more complex and time consuming, and require more frequent appointments than general neurology patients.

The evaluation of this project must consider, in addition to numbers of patients served, the complexity of establishing multiple access points in the community, the resource commitment necessary to train, equip, and deploy EMG and EEG capabilities in another location, and the value to the Region of establishing a neurology residency training program as a long term solution to chronic provider shortages in the specialty.

Category 3 outcomes: The category 3 measures are TBD, but will focus on the rate of seizure re-occurrence in Hispanic patients with epilepsy. The outcome measure was selected considering that Hispanics with epilepsy usually have higher rates of generalist visits, ER care, and hospitalizations, and lower rates of specialist visits. In addition, Hispanics are more likely to have uncontrolled seizures, have side effects of medications, more frequent hospitalizations and a lower overall quality of life Begley et al; Epilepsia 2009May;50(5):1040-50. While these disparities are seen specific to the ethnic group it is also clear that the socioeconomic status influences the disparities

New initiative or enhancement /expansion of an existing initiative. This is a new initiative.

Description:

Project Goal: The overall goal of this project is to address a critical lack of access to neurology providers in our region and to address the geographic distribution of these providers to further improve access.

We propose to accomplish this through three initiatives: 1) over DY2-5 we will recruit a significant cohort of physician and non-physician neurology providers, including general and specialty neurologist, to address the immediate access issues; 2) we will expand to a least one additional geographically distinct site better matching provider resources to patient locations, linking these sites and our primary care providers through an electronic referral system and enterprise EMR, and 3) we will establish a neurology residency program as a long term solution to significant provider shortages in the region.

Challenges: Providers within the Region, both private and public, have been aware of the crisis in neurology care for some time and efforts to address this critical provider shortage have been in place for several years. The Performing Provider has had two open neurology positions for two years and has been unsuccessful in recruiting to these positions. The two largest private hospitals in the Region have likewise had active, yet unsuccessful, neurology searches ongoing for several years.

We believe there are multiple reasons for the failure of these searches. First, there is not a well defined, integrated vision for neurologic care neither within the community nor within the performing provider's strategic plan to date. The recruitment of one or two providers in the face of such profound shortages raises questions of future call coverage support and opportunities for professional collaboration, and is very unappealing. The performing provider's current clinical space is in basement space leased from the state psychiatric facility on our main campus in the Central region. This is exceptionally unattractive to providers as well as patients. We are aware of some resistance from patients to accessing care at this location because of its location within a psychiatric facility.

Finally, we believe the lack of a neurology residency program, and the inability to commit to establishing one, has made the idea of establishing an academic practice in El Paso very unappealing to applicants. We are at a stalemate: Neither the private nor academic settings have been able to address this critical need in our Region.

This project is a bold response to these challenges. We believe that by clearly articulating a programmatic vision that includes the recruitment of significant number of providers AND the establishment of a residency in neurology, we will be able to attract significant interest in these positions. The recruitment of these providers, in turn, begins to address the critical access issues faced by our Region's low income patients. As we develop a provider infrastructure with some redundancy, we are able to provide services in geographically distinct areas of the Region. In addition, the establishment of the residency program will provide a potential source to train people and nurture them to stay in the area.

Included in the Appendix to this project are multiple letters of support from private and military neurologists in our region, confirming the critical need for these services in our region.

Relationship to Regional Goals: This project is responsive to several of our Regional goals; most clearly to increase the number of specialists and services offered in the community. Also important is ability this program will provide to address chronic diseases such as epilepsy, stroke, and dementia.

Expected 5 year outcome for providers and patients:

At the end of DY5, we anticipate having being able to provide a comprehensive, coordinated care to the spectrum of neurologic disease in the Region, integrating primary and specialty care. Indigent and Medicaid patients will experience significantly improved access to neurological services through the recruitment of a large number of providers and a strategy to provide care in geographically separate areas that mirror our population base, and we will have a fully accredited residency program in place.

Baseline: Neurology care in Region 15 is in a state of crisis. In 2010, the Paso del Norte Foundation sponsored a region wide planning symposium addressing and documenting health care needs in a broad area which includes Region 15 This survey documented that Region 15 is underserved in 18 of the 24 assessed specialties and **neurology was identified as one of the top five greatest needs** (1)**.** Data from this survey indicated that the counties comprising Region 15 were underserved by 10 neurologists. These data represent a significant underestimate of our current needs. Since that estimate was obtained, two neurologists (both on the full time faculty of the Paul L. Foster School of Medicine) are no longer practicing in the area; and 3) One neurologist, included in the survey as full time, is actually in administrative medicine and his clinical practice is approximately 20%.

Apart from the acute care of patients with stroke, neurology is largely an outpatient practice; however the status of outpatient neurology is equally dismal or worse. Waiting time for a new patient

appointment to see a provider in the community is believed to be in the range of 90 days. Paul L. Foster school of Medicine, which provides the bulk of neurologic care to indigent and Medicaid populations, has a single neurologist on the full time faculty. **The current time to 3rd available new appointment for this provider is 179 days.** There is no neurology residency program at the current time in this Region. We provide care in a single location in the Region, in central El Paso.

More compelling are the demographics of our existing neurology provider base: of the 10 neurologists in the city not associated with the Military or Veterans systems, 5 graduated medical school in 1975 or earlier suggesting that these providers are nearing the ends of their clinical career and will not likely be able to contribute to any increase in clinical availability. Apart from pediatric neurology and one neuro-interventionalist, the region has no neurologist with fellowship training in any of the subspecialty areas such as dementia, movement disorders, epilepsy or vascular neurology. Hospitals in our RHP are either relying on locums coverage or tele-neurology to meet their in-patient needs.

Our project consists of three key components: 1) We propose to recruit a significant cohort of neurologists in both general neurology and subspecialties, and neurology physician extenders to the Region, 2) establish ambulatory neurology practices in at least one additional location to best match the geographic distribution of patients within our region as well as expand our current ambulatory capacity, and 3) we propose to establish a neurology residency program.

Our recruitment plan consists of recruiting a cohort of 9 FTE neurologists and 2 neurology physician extenders over a 4 year period. We will begin with a senior physician to service as a Chair and establish recruitment priorities. We anticipate recruiting both general neurologists, and specialists in areas such as stroke, neurocritical care, epilepsy, movement disorders, rehabilitation, and dementia. This strategy accomplishes two goals: it provides a continuum of care from primary care to neurologist to neurology subspecialist, and back to primary care, all linked by a common EMR, and it provides the necessary faculty resources to support a neurology residency program.

The existing provider population, including the Performing Provider, is heavily distributed in the central area of El Paso. Geographically, the population of our region is divided in three distinct areas, separated by the Franklin Mountains which split El Paso into the west, central and east areas, with the east representing the faster growth rate. This results in long distances and difficult access conditions, particularly for those who depend on public transportation.

As a solution to this challenge, we propose to establish ambulatory outpatient neurology services to at least one additional site within our Region over the 4 year demonstration project and evaluate the feasibility of a 3rd distinct site. The planning process will include a needs assessment, evaluation of current patient demographics, review of potential ambulatory sites and a feasibility study of including ancillary testing such as EMG and EEG in this site. Once the first site is established, we will begin an evaluation process for a 3rd geographically distinct site.

We intend to establish a neurology residency program. The need for additional residency slots is critical. Nationally in 2012, only 346 categorical neurology slots were offered. This actually represents a decline of 13% over 5 years in the number of slots offered. However fill rates for slots have averaged 95% over this same time period, so there is every reason to believe that opening additional residency positions will lead to an increase in neurologists (1). Since most West Texas medical residents stay within a 75 mile radius of their training site to set up practice (2), a neurology residency represents the single best way to address, in a sustainable manner, the provider base necessary to meet our region's needs, and also addresses a core reason for the failure of multiple neurology searches to date in the Region by both academic and private providers.

The process of establishing a residency de novo is a 2.5 to 3 year process, and requires the expenditure of substantial resources in planning educational needs, establishing affiliations, recruitment of faculty, review and approval of the residency plan by national accrediting organizations PRIOR to the being able to recruit and accept trainees into the residency. As such, it is a logical and appropriate project for funding intended to transform the care delivery system.

The third goal of this project is to reduce the average time to third available new appointment to 60 days or less. Given the current wait time of 179 days, this represents a profound improvement. We are hopeful that the full funding and implementation of this DSRIP project will result in even shorter wait times, however given the current wait times and provider shortages, it is impossible to measure the unmet demand in our population.

In the face of a geographically distributed provider base, electronic means of communication are critical to achieving efficiencies in the referral process and return to the primary care provider. As part of the infrastructure development for this project, we will investigate, deploy and utilize an electronic referral system between primary care providers and neurology within the enterprise.

The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. Unfunded and low income patients rely heavily on our services. Thirty-seven percent of CDC's Behavioral Risk Factor Surveillance System respondents from El Paso, the predominant population center in our region, report no health insurance, compared to a nationwide rate of 15.1%. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. Given the profound shortage of neurology providers in the region, it is highly unlikely that this vulnerable population will have access to these services apart from this project. The development of neurology services within the Performing Provider represents the best opportunity to integrate care management, primary care and necessary consultative services through a single provider referral network and EMR to meet well documented needs of our unfunded and Medicaid patient base.

In support of this, we will engage in a process of regular interaction and feedback across our enterprise and the RHP. In DY 1 and 2, our milestones reflect the recruitment of neurology providers and the planning for an electronic referral system. Consequently, we will engage clinical affairs, finance, providers, and information technology in this effort. Subsequent DY's will engage the Office of Graduate Medical Education in support of establishing the residency program. We will participate in learning initiatives sponsored by the RHP in DY2-5.

Rationale:

Project Components: We chose project option 1.9.3 "Other" project option as the best fit for this project.

a) Identify high impact/most impacted specialty services and gaps in care and coordination
b) Increase the number of residents/trainees choosing targeted shortage specialties
c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)
d) Increase number of specialty clinic locations
e) Implement transparent, standardized referrals across the system
f) Conduct quality improvement for project

We have already identifies neurology as a representing a high impact provider shortage issue, proposed substantial recruitment of these specialists to the Region, and an increase in training of residents through the establishment of a training program. The project also contains substantial elements of 1.9.2 including an enhanced referral system and multiple clinic locations. We anticipate the quality improvement component will be accomplished in at least monthly meetings with providers, school leadership, EMR, IT and finance as this highly integrated project is rolled out.

The metrics we have chosen for our milestones reflect specific steps required to accomplish these ambitious goals; the most important of which is the recruitment of a large number of providers needed in the region as documented by the needs assessment. Additionally, the roll out of an electronic referral system requires tight integration between the providers, IT and EMR, and these metric reflect those steps.

Community Need: This project reflects CN.2: improving access to secondary and specialty care within the region.

How does this project reflect a new initiative or a significantly enhances an existing initiative. This is a new initiative for the performing provider. As noted above, a neurology residency, a large cohort of neurology providers, and the provision of care in geographically distinct areas have never been contemplated by the Performing Provider prior to this waiver opportunity.

Related Category 3 Outcomes

We propose the following Category 3 outcomes to support this project:

OD-11 Addressing Health Care Disparities in Minority Populations:

- **IT-11.1 Improvement in Clinical Indicator in identified disparity group:** We propose to utilize a metric which reflects a decrease in the rate of reoccurrence of seizures in a Hispanic population with epilepsy followed in our neurology program .

The outcome measure was selected considering that Hispanics with epilepsy usually have higher rates of generalist visits, ER care, and hospitalizations, and lower rates of specialist visits. In addition, Hispanics are more likely to have uncontrolled seizures, have side effects of medications, more frequent hospitalizations and a lower overall quality of life Begley et al; Epilepsia 2009 May; 50(5):1040-50. While these disparities are seen specific to the ethnic group it is also clear that the socioeconomic status influences the disparities

Relationship to Other Projects and Measures:

This project has potential relationships to two other projects proposed by the Performing Provider:

084597603.2.1 - The establishment of a Medical Home in the Department of Family Medicine ambulatory program. The linking of primary and specialty care, inherent in the design of a medical home, is essential to the appropriate, timely, and cost effective delivery of care. Since many of these patients are likely to have chronic illnesses, the establishment of a primary care team, linked by a common EMR, will optimize care.

084597603.1.2 - The Establishment of a Disease Management Registry and The Disease Management Registry program proposes to focus initially on Diabetes which is disproportionally present in our

population. Nonetheless, the infrastructure and capabilities being developed with the establishment of a Disease Management Registry are easily adaptable to chronic conditions commonly seen in a neurology practice such as stroke, Parkinson's disease, epilepsy and dementia.

Relationship to Other Providers' Projects in the RHP: A number of our Regional partners are creating discharge navigation programs. We anticipate interacting with these providers to facilitate the smooth transition of patients with neurological disease to the outpatient setting.

Plan for Learning Collaborative: We will participate in the Region's learning collaborative.

Project Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

1. Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

2. National Resident Matching Program, Results and Data: 2012 Main Residency Match. National Resident Matching Program, Washington, DC. 2012.

3. Texas Tech University Health Sciences Center Factbook. Sixteenth ed December 2008.

084597603.1.3	***1.9.3***	***PROJECT COMPONENTS: 1.9.3***	A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.5	IT-11.1	Improvement in Clinical Indicator in identified disparity group

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-7]: Complete a planning process/submit a plan to implement electronic referral technology Metric 1 [P-7.1]: Development of a staffing plan for referral system. Goal: Development of a staffing plan for the implementation of Secure Messenger or similar functionality as an electronic referral system Data Source: Referral plan, describes the number and types and staff and their respective roles needed to implement the system. Metric 2: [P-7.2]: Development of an implementation plan for e-referral. Goal: Development of an implementation plan for the utilization of Secure Messenger or similar functionality as a referral system. Data Source: e-Referral implementation plan, which describes the technical mechanisms needed to operate e-referral system. Milestone 1 Estimated Incentive Payment: $620,000	**Milestone 6 [**P-8]: Develop the technical capabilities to facilitate electronic referral. Metric 1 [P-8.1]: Demonstrate technical mechanisms to be used to operate referral system are in place. Goal: This includes the recruitment and / or allocation of IT resources to implement and manage this process, the acquisition and deployment of required hardware and software elements to support this functionality, and training of end users in the Departments of Family Medicine and Internal Medicine. Data Source: Documentation of acquisition and deployment of required hardware and software, and training of end users as defined in implementation plan developed as DY 2 Milestone Milestone 6 Estimated Incentive Payment: $486,311 **Milestone** 7 [I-22]. Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties.	**Milestone 13** [P-9]: Implement referral technology and processes that enable improved and more streamlined provider communications. Metric 1[p-9.1] Documentation of a functional electronic referral system Goal: A secure electronic referral system will be operating between performing provider neurologists and primary care providers. Data Source: Referral system. The Department of Neurology will maintain an electronic record of consults received electronically to support documentation of achieving this milestone. Milestone 13 Estimated Incentive Payment: $ 606,946 **Milestone 14** [I-31]: Increase TSC training and/or rotations. Metric 1 [p31.1]: Increase the number of TSC residents and/or trainees, as measured by percent change of class size over baseline. Goal: Department shall expand the neurology residency program from zero to 2 residents	**Milestone 19** [I-23] increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [1-23.2]: Documentation of increased number of unique patients. Goal: The Department will increase the number of unique patients seen by the Department of Neurology by 25% compared to DY4. We estimate to see 1170 unique patients in DY5 Data Source: Scheduling system, EMR Milestone 19 Estimated Incentive Payment: $879,634 **Milestone 20** [1-31]]: Increase TSC training and/or rotations. Metric 1 [p31.1]: Increase the number of TSC residents and/or trainees, as measured by percent change of class size over baseline. Goal: Department shall expand the neurology residency program by 100% from DY4 level (2 residents to 4 residents) Data Source: Office of GME documentation

084597603.1.3	***1.9.3***	***PROJECT COMPONENTS: 1.9.3***	A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.5	IT-11.1	Improvement in Clinical Indicator in identified disparity group

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-X-1]: Planning process to expand clinical sites. Metric [P-x-1]: This milestone represents the required planning process to establish a 2nd ambulatory neurology site apart from the current Alberta location. Goal: Complete a needs assessment, analysis of existing patient locations, a space, hardware and personnel support requirements assessment, and IT and EMR requirements assessments. Data Source: A written document documenting institutional collaboration and planning addressing the elements contained in Milestone 3 Milestone 2 Estimated Incentive Payment: $620,000 **Milestone 3: [**I-22] Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and / or procedure hours available for the	Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties. Goal: We will increase the number of neurologist and /or neurology physician extenders employed by PP to six. Data Source: HR documents demonstrating employment within DY 3. Milestone 7 Estimated Incentive Payment: $486,311 **Milestone 8** [P-16]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents. Metric 8:[P16.1]: ACGME approval for residency position expansion. Baseline: establish a neurology residency program (note that a residency program in neurology does not currently exist at the PLFSOM, therefore the request to ACGME is to establish a program, rather than	Data Source: Office of GME documentation Milestone 12 Estimated Incentive Payment: $ 606,946 **Milestone 15** [I-22]: Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties. Baseline /Goal: We will increase the number of neurologist and /or neurology physician extenders employed by PP to 8. Data Source: HR documents demonstrating employment within DY 4. Milestone 15 Estimated Incentive Payment: $ 606,946 **Milestone 16** [I-23]: increase specialty care clinic volume of visits and evidence of improved access for	Milestone 20 Estimated Incentive Payment: $879,634 **Milestone 21** [I-22]. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and / or procedure hours available for the high impact/most impacted medical specialties. Baseline /Goal: We will increase the number of neurologist and /or neurology physician extenders employed by PP to 10. Data Source: HR documents demonstrating employment within DY 4. Milestone 21 Estimated Incentive Payment:$879,634 **Milestone 22 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers.

084597603.1.3	***1.9.3***	***PROJECT COMPONENTS: 1.9.3***	A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.5	IT-11.1	Improvement in Clinical Indicator in identified disparity group

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)**
high impact/most impacted medical specialties. Goal: We will increase the number of neurologists employed by PP from the existing one to three. Data Source: HR documents demonstrating employment within DY 2. Milestone 3 Estimated Incentive Payment: $620,000 **Milestone 4 [P-1]:** Conduct specialty care gap assessment based on community need: Metric 1: [P-1.1]: Documentation of Gap assessment. Data Source: Gap analysis repot Milestone 4 Estimated Incentive Payment: $620,000 **Milestone 5[P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will	increase the number of neurology residents) Data Source: Documentation of ACGME approval of the residency program. Milestone 8 Estimated Incentive Payment: $486,311 **Milestone 9** [I-23]:Increase specialty care clinic volumes of visits and evidence of improved access for patients seeking services Metric 1 [1-23.2]: Documentation of increased number of unique patients. Goal: The Department will increase the number of unique patients seen by the Department of Neurology by 25% compared to DY2. We estimate the DY2 baseline number of unique patients to be approximately 600. We will see 750 unique patients in DY3 Data Source: Electronic scheduling system Milestone 9 Estimated Incentive Payment: $486,311 **Milestone 10** [P-X-1]: Planning process to expand clinical sites.	patients seeking services. Metric 1 [1-23.2]: Documentation of increased number of unique patients. Goal: The Department will increase the number of unique patients seen by the Department of Neurology by 25% compared to DY3. We estimate to see 940 unique patients in DY4 Data Source: Electronic scheduling system Milestone 16 Estimated Incentive Payment: $ 606,946 **Milestone 17** [I-33] Increase specialty care capacity using innovative project options. The Department shall increase neurology care capacity by establishing a 3rd ambulatory neurology location, distinct from the current Alberta location Metric 1 [I-33.1] Documentation of increased number of unique patients, or size of patient panels. Goal: The performing provider will see a minimum of 300 new unique patients at the 3rd ambulatory location. (New is defined as not	Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings Milestone 22 Estimated Incentive Payment:$879,634

084597603.1.3	***1.9.3***	***PROJECT COMPONENTS: 1.9.3***	A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.5	IT-11.1	Improvement in Clinical Indicator in identified disparity group

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)**
sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 5 Estimated Incentive Payment: $620,000	Metric [P-x-1]: This milestone represents the required planning process to establish a 2nd ambulatory neurology site apart from the current Alberta location. Goal: Complete a needs assessment, analysis of existing patient locations, a space, hardware and personnel support requirements assessment, and IT and EMR requirements assessments. Data Source: A written document documenting institutional collaboration and planning addressing the elements contained in Milestone 10 Milestone 10 Estimated Incentive Payment: $486,311 **Milestone 11** [I-33]: Increase specialty care capacity using innovative project options. The Department shall increase neurology care capacity by establishing a 2nd ambulatory neurology location, distinct from the current Alberta location <u>Metric 1 [I-33.1]</u> Documentation of increased number of unique patients,	previously having been seen by a neurology provider with the PLFSOM system). Data Source: Electronic Scheduling System Milestone 17 Estimated Incentive Payment: $ 606,946 **Milestone 18 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. <u>Metric 1</u> [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 18 Estimated Incentive Payment:$ 606,946	

084597603.1.3	***1.9.3***	***PROJECT COMPONENTS: 1.9.3***	A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.5	IT-11.1	Improvement in Clinical Indicator in identified disparity group	
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)**
	or size of patient panels. Goal: The performing provider will see a minimum of 300 new unique patients at the 2nd ambulatory location. (New is defined as not previously having been seen by a neurology provider with the PLFSOM system). Data Source: Electronic Scheduling System Milestone 11 Estimated Incentive Payment: $486,311 **Milestone 12 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. <u>Metric 1</u> [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 12 Estimated Incentive			

084597603.1.3	***1.9.3***	***PROJECT COMPONENTS: 1.9.3***	A Proposal to Expand Neurology Care to a Multi-site, Geographically Distributed Ambulatory Neurology Network	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.5	IT-11.1	Improvement in Clinical Indicator in identified disparity group	
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:$486,311			
Year 2 Estimated Milestone Bundle Amount: $3,100,000	Year 3 Estimated Milestone Bundle Amount: $3,404,177		Year 4 Estimated Milestone Bundle Amount: $3,641,676	Year 5 Estimated Milestone Bundle Amount: $3,518,536
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 13,664,389				

95693

Project Option: 1.9.1 project option - The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC)

Unique Project ID: 084597603.1.4
RHP Performing Provider / TPI : TEXAS TECH HS CTR FAMILY MED / 084597603
Project Title: The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC)

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: The project has 3 major interventions: 1) recruit a fellowship trained surgical oncologist or breast surgeon to supplement the existing general surgery resources 2) establish an accredited fellowship program in breast care and 3) establish a survivor's program for women who have completed therapy for breast cancer.

Need for the project: The UBCC cares for women with breast cancer regardless of ability to pay and is the primary provider of services for screening, diagnosis and treatment of breast disease to women in the region without insurance. There are no fellowship trained breast surgeons, and only one surgical oncologist in the region, meaning essentially no access to this specialty for women without insurance, and very limited access to those with Medicaid. Recruitment of this specialty, and the establishment of a breast fellowship, will address critical provider shortages. Hispanic women, who represent the overwhelming majority of women served by the UBCC, have unique issues including higher rates of depression and psychological stress at diagnosis, and more aggressive tumors. There are no formal survivorship programs in the region.

Target Population:
The UBCC provides approximately 3300 outpatient visits/year. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. Within the UBCC, this percentage rises to 66%, the majority of which are women with no insurance.

Category 1 or 2 expected benefits : Patients will benefit from care provided by a fellowship trained surgeon, improved access to care through the establishment of a training program, and reductions in wait times for 3rd next available new appointment. Given the anticipated CMS approval date for this project and recruitment requirements, there may be no unique patients seen by a fellowship trained surgeon in DY2. For the remaining years:

Unique patients who receive care by Breast Surgeon / Surgical Oncologist
DY2 0 DY3 125 DY4 275 DY5 300

The main value of the recruitment of this surgeon is NOT to increase the number of unique patients seen; it is raise the level of care for breast disease provided to these women compared to the current practice of care by general surgeons. Furthermore, the recruitment of this specialist service is a

requirement to establish a training program in breast disease, which is the best long term solution to address access for low income women in a sustainable manner.

Category 3 outcomes: The project includes a Quality of Life intervention which lasts two years. We will recruit two separate cohorts of patients: one in DY2 (DY2 cohort) which completes the program in DY4, and one in DY3 (DY3 cohort) will complete the program in DY5. 45% of DY2 cohort patients will have meaningful improvements or have reported a normal quality of life using a standardized survey tool after completing the two year survivor's program, 50% of the DY3 cohort patients will meet this standard. We will enroll a minimum of 60 patients in each cohort.

New initiative or enhancement /expansion of an existing initiative: This project represents significant enhancements to the existing UBCC.

Project Description:

The University Breast Care Center began operation in 1994 providing comprehensive breast care for the Region's medically indigent women with breast disease. Currently twenty-five (25%) of patients seen there have no third party insurance, and the majority of the remainder have only Medicaid. Collectively, the Center provides care for approximately 1/3 of the women in the El Paso area with a new diagnosis of breast cancer, and is the primary provider of care to women with breast disease who lack health insurance. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. Within the UBCC, this percentage rises to 66%, the majority of which are women with no insurance. The adjacent University Hospital mammogram facility performed nearly 12,000 mammography exams in the year ending May 2012, of which approximately 70% were screening exams and the remainder diagnostic.

In El Paso County is located on the U.S. Mexico border in far west Texas. El Paso County, which representaed the overwhelming majority of patients in Region 15, has a population of 721,598 individuals of which 81% identify themselves as Hispanic. Seventy-five percent of individuals age five and over speak a language other than English at home. The citizens of El Paso County, by far the most populous of the two counties in our region,experience many disparities: 25% of families report annual income below the poverty level and 39% of residents lack health insurance of any kind.

After 18 years, the UBCC continues to be unique in El Paso. It is the only program incorporating screening, diagnosis, treatment and education in a single location, providing care women of our Region with breast disease. Our program has evolved and is now dedicated to providing quality, comprehensive and integrated care for diagnosis, treatment, and education to all women in the Region with breast diseases and specially Breast Cancer as well as developing a clinical and laboratory program to study the prevention, early detection, and treatment of breast cancer. The program has received accreditation by The National Accreditation Program for Breast Centers (NAPBC) through the American College of Surgeons.

Baseline: The primary surgical support to UBCC is its founder, a general surgeon. Furthermore, access to this surgeon is delayed: with the **time to 3rd new patient visit currently at 25 days.** In the case of breast and oncology surgeons, there is a single fellowship trained surgical oncologist, in private practice, in Region 15. There are no breast fellowship trained surgeons in Region 15. This situation mirrors the crisis in surgical care throughout our Region. A 2010 health needs assessment, sponsored by the Paso del Norte Foundation and which serves as primary guidance informing the Region 15 RHP

documented that the area is underserved in 18 of the 24 assessed specialties and **surgery was the second greatest numerical need**[1]. There is a need for approximately 50 surgeons in our RHP and more than 95 when including our traditional referral areas including southeastern New Mexico and Juarez. Given the high demand for surgical services in our Region as a manifestation of these provider shortages, and the payor mix of UBCC, it is not reasonable to expect the private community will be able to meet the needs of our current patient population, nor will it recruit surgeons with specific fellowship training in oncology or breast surgery to care for this population, and it will not likely invest in the Quality of Life initiative included in this proposal.

Project Goals: This project will accomplish three goals:

1) Expand and enhance access to specialty care for women with breast disease through the addition of a fellowship trained breast surgeon or surgical oncologist to the staff of the UBCC

2) Develop a fellowship program in breast surgery to address a critical regional shortage of surgeons,
and provide increased access to surgeons with special expertise in breast surgery

3) Establish a survivor's program in the UBCC, with an emphasis on objective measures of quality of life, and strategies to improve this metric.

The recruitment of a fellowship trained breast surgeon or surgical oncologist provides a level of expertise to our indigent and Medicaid population that is essentially unavailable to them currently. Leveraging this resource, the establishment of a fellowship in breast surgery represents the best solution to the long term provider shortage in our region, since most West Texas medical residents stay within a 75 mile radius of their training site to set up practice[2].

The development of a fellowship de novo is a time consuming and expensive process. More importantly, given current access times are at 25 days, it is important to bring on an additional surgeon with specific training in the care of oncology patients, at the same time we develop this fellowship application. The Society of Surgical Oncologists, not ACGME, is the accrediting body for a breast fellowship.

The number of cancer survivors is growing for several reasons, including early detection, more accurate diagnosis, and more effective treatment [3, 4] . Breast cancer survivors comprise the largest proportion at 22% of all survivors; right now there are more than 2½ million breast cancer survivors in the United States [4]. However, at least one third of survivors experience ongoing physical, psychological or financial consequences of their cancer diagnosis and treatment [5, 6]. Appropriate follow-up care is often not delivered and the psychosocial needs of cancer patients are often not addressed [6] .Also, many patients finish their primary treatment for cancer unaware of their heightened health risks and are ill prepared to manage their future health care needs[6]. Barriers that patients face in receiving appropriate care include a fragmented and poorly coordinated health care system, an absence of a focus of responsibility for follow-up care, and a lack of guidance on how cancer survivors can maximize their own health outcomes. Barriers that health care providers face in delivering care include not having necessary tools to provide consistent quality care, lack of a delivery system supports that would allow them to overcome some of the obstacles posed by fragmented cancer care, and lack of adequate reimbursement of many services in survivor care [7]. Furthermore, extended cancer survival is a relatively new phenomenon, so the current pace of research and development of effective models of care lags behind the need.

Hispanic patients may have additional needs compared to breast cancer survivors from other ethnic groups. A recent exploratory research at the University of Chicago including 989 newly diagnosed breast cancer patients suggested an association between psychosocial stress post-diagnosis (in the form of fear, anxiety, or isolation) and breast cancer aggressiveness[8]. The rate of post-diagnosis psychosocial stress was about two-fold higher in Hispanics. Also, social/environmental stress could affect epigenetics, such as DNA methylation, and increased stress can impact immune function adversely[9]. Therefore, specific stress-reduction strategies should be recommended. Another study including 117 Hispanic Breast cancer survivors at the University of Texas, San Antonio found that Hispanic breast cancer survivors have a high rate of depression and that, piled on other barriers like cost factors and underinsurance, prevents many of them from getting screenings for other cancers like colon cancers(only 5% get appropriate screening)[10]. This is significant because 10% of all new cancers are diagnosed in cancer survivors and second cancers are the 6th leading cause of cancer deaths, highlighting the need for regular screenings in cancer survivors. One of the explanations provided is that many Hispanic breast cancer survivors equate their cancer to a death sentence, and many do not want to "bother" their physicians for screening. We surveyed 65 of our breast cancer survivors and noted that around 35% consider their general health fair or poor, and 50 % of them feel their physical health or emotional problems interfere with their social activities [data on file, to be presented in CPRIT conference, Austin, TX October 25, 2012], using a validated Health related survey RAND/HSF-36[11], Spanish version[12].

Based on this and similar research we feel that Hispanic breast cancer survivors should not only get the oncology follow-up treatment they need, but should also be screened for depression and other stressors and their individual's need explored (for example concern about cancer recurrence or sexual issues) and should receive appropriate education and coping strategies. Also, another study looking at the characteristics of 111 breast cancer patients in our center showed that median Body Mass Index (BMI) Index is high 35.5 (range 18-50.4) and many of our Hispanic breast cancer patients in El Paso are diagnosed at a younger age (32% were diagnosed at younger than age 50 years)[13.]

Based on the data above, we believe that our breast cancer survivors would be best served in a comprehensive survivorship program as proposed in this grant application that would focus on their specific needs and address their dietary, cultural and lifestyle habits. Evidence suggests that interventional proactive programs developed for women who have completed treatment for breast cancer addressing survivorship issues like psychological well-being and functional wellness are useful for a successful transition to survivorship following breast cancer and have a significant potential to improve recovery and quality of life for survivors of breast cancer [14-17].

The primary endpoint for our Category 3 milestones and metrics for this project will be improvements in the Quality of Life as assessed by a standardized assessment tool, the Health related SF-36 Survey. We will measure Quality of Life at entry in the program, every 6 months and at the completion of Year 1 and Year 2 in the survivorship care program. The survivors program is a rolling 2 year program. We will recruit two separate cohorts of patients: one in DY2 (DY2 cohort) which completes the program in DY4, and one in DY3 (DY3 cohort) will complete the program in DY5. 45% of DY2 cohort patients will have meaningful improvements or have reported a normal quality of life using a standardized survey tool after completing the two year survivor's program, 50% of the DY3 cohort patients will meet this standard.

Challenges: Our primary challenge will be to recruit a surgeon with the desired fellowship training to our program. We believe the vision of the program is compelling, and together with commitments the performing provider has made in research related to breast cancer, will be .

Relationship to Regional Goals: This project meets our Regional goals of expanding access to specialty care and the services offered with our community, and enhance the Region's ability, in a very significant manner, to care to patients with a chronic disease such as breast cancer and its sequel. It will enhance the Regional goal of overcoming socio-economic and monetary barriers to accessing healthcare in our Region

5 – year expected outcome for patients and providers: At the end of DY 5, we anticipate that nearly all patients with breast cancer seen in the UBCC will have access to a fellowship trained breast surgeon or surgical oncologist, that there will be a functioning fellowship program in breast disease, and that we will be able to, using objective measures, demonstrate meaningful improvements in the Quality of Life of survivors of breast cancer.

Given the anticipated CMS approval date for this project and recruitment requirements, there may be no unique patients seen by a fellowship trained surgeon in DY2. For the remaining years:

Unique patients who receive care by Breast Surgeon / Surgical Oncologist
DY2 0 DY3 125 DY4 275 DY5 300

Rationale:

We chose Project Option: 1.9.1. encompassing elements a-c. In addition, our proposal includes the development of a survivors program addressing Health Related Quality of Life for survivors of Breast Cancer which did not readily fit into Option 1. We propose to address quality initiatives through the requirements of accreditation by The National Accreditation Program for Breast Centers (NAPBC), and those requires by the accrediting body for the breast fellowship. In addition, we will participate in RHP sponsored learning collaboratives.

The metrics we propose reflect these goals. They are focused on developing the infrastructure in terms of personnel to develop a Breast fellowship without impacting current access to the UBCC, planning and submission of the required elements to obtain approval for a fellowship, deploying the survivor's program and improving access times as measured by the time to 3rd next available appointment

Community Need: This project addresses CN.2, access to secondary / specialty care.

How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative: As noted, the Region's access to fellowship trained breast surgeons or surgical oncologists is extremely limited. The specific recruitment of this specialty to our program represents a significant enhancement to a well establish breast care program. Quality of Life in survivors of breast cancer is an area in which we have obtained pilot data to demonstrate the need, but simply have no funding to be able to add this service to our program with this waiver. As such, it too represents a significant enhancement to an existing program.

Related Category 3 Outcome Measures: We have chosen OD-10, IT-10.1 Quality of Life as a standalone outcome measure. The importance of quality of life in cancer survivors is addressed in our narrative and is the reason why we chose this milestone. This will directly reflect the impact the survivor's program has had on eligible patients. Improved quality of life, as addressed in the narrative above, is an important aspect of the spectrum of cancer care, and an area that Hispanics are at particular risk of facing challenges in following treatment for breast cancer.

Relationship to Other Projects and Measures:

This project reinforces 084597603.1.2 Implement a Chronic Disease Management Registry proposal since breast cancer will be one of the initial disease managed in the registry. It also links directly to 084597603.2.1 The Development of a Primary Care Medical Home in a Health Professions Shortage Area since many of these women will require ongoing primary care. Linkage through our enterprise EMR will facilitate seamless communication between primary care, the UBCC, and the survivor's program.

Relationship to Other Providers' Projects in the RHP: No other providers are contemplating a project specifically aimed at breast cancer; however several entities are proposing initiatives to increase primary care access. We believe that these initiatives will enhance referrals to the UBCC

Plan for Learning Collaborative: We will participate in RHP sponsored learning collaboratives.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

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084597603.1.4	***1.9.1***	***PROJECT COMPONENT 1.9.1 (A-C)***	The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC)
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.6	*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-3]: To collect baseline data for wait times, backlog, and/or return appointments in specialty. Metric 1 [*P-3.1*]: establish a baseline for time to 3rd available new patient appointment. Data Source: EMR and scheduling system reports Rationale: Establishing baseline data on access is critical assessing improvements. Milestone 1 Estimated Incentive Payment *(maximum amount):* $226,435 **Milestone 2** [P-11]: Launch a specialty clinic: Metric [P-11.1]: Establish / expand specialty care clinics. The Breast Cancer Survivor's Program. Eligible patients are all patients with a diagnosis of breast cancer. Patients should have completed surgery and treatment with chemotherapy and radiation therapy. Goal: the program will offer enrollment to 40 women. Data Source: EMR, survivor's	**Milestone 6** [P-14]:Expand TSC training Metric 1 [P-14.1]: Expand the TSC residency. Goal: Performing Provider will complete and submit application to the Society of Surgical Oncologists in support of a new fellowship program in Breast Surgery. Data Source: Application documents. Milestone 6 Estimated Incentive Payment *(maximum amount):* $248, 654.40 **Milestone 7** [P-11]: Launch a specialty clinic. Metric [P-11.1]: Establish / expand specialty care clinics. The Breast Cancer Survivor's Program. Eligible patients are all patients with a diagnosis of breast cancer. Patients should have completed surgery and treatment with chemotherapy and radiation therapy. Metric 1 [P-11.1]: Goal: the program will offer enrollment to 75 new women. Data Source: EMR, survivor's program records.	**Milestone** 11 [P-16]:Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents Metric 1 [P-16.1]: ACGME approval for residency position expansion. Goal: Approval by the Society of Surgical Oncology (which accredits this training position, not ACGME) to establish fellowship program in breast oncology. Data Source: Accreditation documents Milestone 11Estimated Incentive Payment *(maximum amount):* $266,002.40 **Milestone 12**[I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.1]: Increase the number of TSC residents and/or trainees, as measured by percent change of class size over baseline Goal: Increase from zero to one, the number of fellows in the training program Data Source: GME documents	**Milestone** 16[I-30]: Reduce the number of specialty clinics with waiting times for the next routine appointment Metric 1 [I-30.1]: Next routine appointment of more than x calendar day. Reduce time to 3rd new patient appointment Goal: Time to 3rd new patient appointment for a UBCC surgeon will be reduced by 15% from time in DY4. Data Source: EMR, scheduling reports. Milestone 16 Estimated Incentive Payment *(maximum amount):* $428, 345 **Milestone** 17 [P-21]: Metric 1 [P-21.1]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify

084597603.1.4	***1.9.1***	***PROJECT COMPONENT 1.9.1 (A-C)***	The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC)
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.6	*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)**
program records. Milestone 2 Estimated Incentive Payment *(maximum amount):* $226,435 **Milestone 3** [P-14]: Expand TSC training to provide sufficient faculty support to establish a breast fellowship Metric 1 [P-14-2]: Hire additional precepting TSC faculty members. Goal: Will hire a fellowship trained surgical oncologist or Fellowship trained breast surgeon. Data Source: HR records Milestone 3 Estimated Incentive Payment *(maximum amount):* $226,435 **Milestone 4** [P-21]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement.	Milestone 7 Estimated Incentive Payment *(maximum amount):* $248, 654.40 **Milestone 8** [P-21]: Metric 1 [P-21.1]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 8 Estimated Incentive Payment *(maximum amount):* $248, 654.40 **Milestone 9** [I-30]: Reduce the number of specialty clinics with waiting times for the next routine appointment Metric 1 [I-30.1]: Next routine appointment of more than x calendar day. Reduce time to 3rd new patient appointment	Milestone 12Estimated Incentive Payment *(maximum amount):* $266,002.40 **Milestone** 13 [I-30]: Metric 1 [I-30.1]: Reduce the number of specialty clinics with waiting times for the next routine appointment Metric 1 [I-30.1]: Next routine appointment of more than x calendar day. Reduce time to 3rd new patient appointment Goal: Time to 3rd new patient appointment for a UBCC surgeon will be reduced by 15% from time in DY3. Data Source: EMR, scheduling reports. Milestone 13 Estimated Incentive Payment *(maximum amount):* $266,002.40 **Milestone** 14[P-21]: Metric 1 [P-21.1]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP	opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 17 Estimated Incentive Payment *(maximum amount):* $428, 345 **Milestone 18:[I-23]: Increase specialty clinic volumes** **Metric I-23.2:Documentation of increased number of unique patients** Goal: Breast Surgeon / Surgical Oncologist will provide treatment to 300 unique patients Data Source: Billing records, scheduling system, EMR Rationale: This metric reflects the provision of a higher level of care envisioned by this project Milestone 18 Estimated Incentive Payment *(maximum amount):* $428, 345

084597603.1.4	***1.9.1***	***PROJECT COMPONENT 1.9.1 (A-C)***	The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC)
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.6	*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: Meeting flyers, slides, notes from meetings. Milestone 4 Estimated Incentive Payment *(maximum amount):* $226,435 **Milestone 5:[I-X]:** Achieve National Accreditation Metric I-X.1: Achieve national accreditation. Goal: Achieve accreditation by The National Accreditation Program for Breast Centers (NAPBC) Data Source: Accreditation letter Rationale: The NAPBC accreditation provides for specific quality tracking and reporting which will meet the needs our selected project option. Milestone 5 Estimated Incentive Payment *(maximum amount):* $226,435	Goal: Time to 3rd new patient appointment for a UBCC surgeon will be reduced by 15% from baseline established in DY2 Data Source: EMR, scheduling reports. Milestone 9 Estimated Incentive Payment *(maximum amount):* $248, 654.40 **Milestone 10:[I-23]: Increase specialty clinic volumes** **Metric I-23.2:Documentation of increased number of unique patients** Goal: Breast Surgeon / Surgical Oncologist will provide treatment to 125 unique patients Data Source: Billing records, scheduling system, EMR Rationale: This metric reflects the provision of a higher level of care envisioned by this project Milestone 10 Estimated Incentive Payment *(maximum amount):* $248, 654.40	sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 14 Estimated Incentive Payment *(maximum amount):* $266,002.40 **Milestone 15:[I-23]: Increase specialty clinic volumes** **Metric I-23.2:Documentation of increased number of unique patients** Goal: Breast Surgeon / Surgical Oncologist will provide treatment to 275 unique patients Data Source: Billing records, scheduling system, EMR Rationale: This metric reflects the provision of a higher level of care envisioned by this project Milestone 15 Estimated Incentive Payment *(maximum amount):* $266,002.40	

084597603.1.4	***1.9.1***	***PROJECT COMPONENT 1.9.1 (A-C)***	The Expansion and Enhancement of Comprehensive Breast Care Services to an Indigent and Underserved Population in the University Breast Care Center (UBCC)	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.6	*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)**
Year 2 Estimated Milestone Bundle Amount:*):* $1,132,175	Year 3 Estimated Milestone Bundle Amount: $1,243,272		Year 4 Estimated Milestone Bundle Amount: $1,330,012	Year 5 Estimated Milestone Bundle Amount: $1,285,035
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,990,494				

95688

Project Option 1.9.2 - Expanding access to surgical services to a Hispanic population

Unique Project ID: 084597603.1.5
Performing Provider Name/TPI: TEXAS TECH HS CTR FAMILY MED /TPI: 084597603
Project Title: Expanding access to surgical services to a Hispanic population

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will 1) increase the number of surgical providers serving the region 2) expand the number of sites at which the performing provider offers outpatient general surgery clinic services, and 3) implement an electronic referral system.

Need for the project Surgery is the second greatest numerical need in our Region, numbering approximately 50 additional providers to meet the needs of our region. The average time to 3rd new patient appointment for general surgery services by the Performing Provider is 44 days.

Target Population:
a) Each new surgical provider, when established, will provide services to a minimum of 250 unique patients each year. Given the anticipated time frame of CMS approval of this project, and recruitment timelines, the estimated impact for DY2 is 125 unique patients. We estimate, on average, each new surgeon will provide services to a minimum of 125 patients in their first DY, rising to 250 in subsequent years. The total number of unique patients served will be
DY2:125 DY3:375 DY4:500 DY5:875

b) Benefit to Medicaid / Indigent Patients: Given that 60% of our enterprise ambulatory encounters are to patients with Medicaid or no insurance, this project will be a direct benefit to that population.

Category 1 or 2 expected benefits : In addition to the increased numbers of unique patients seen, we will establish a 2nd site of ambulatory general surgery and implement and increase utilization of an electronic referral system.

Category 3 outcomes: Our goal is to increase the number of patients who report a satisfaction score of 80% or greater by 10% over the previous year in DY 4 and 5 OR be >= 70% in DY 4 and 75% in DY5

New initiative or enhancement /expansion of an existing initiative: This represents an enhancement of the existing general surgery services provided.

Project Goals: The overall goal of this project is to address a critical shortage of surgical providers in our region and to address the geographic distribution of these providers to further improve access. We propose to accomplish this goal through three strategies: 1) to recruit surgeons and surgical physician extenders to the region; 2) To expand the number of sites at which the performing provider offers outpatient general surgery clinic services, and 3) to streamline the referral process from primary care

providers to the surgical program and back to primary care by creating and implementing an electronic referral system.

Baseline: Surgical care in Region 15 is in a state of crisis. A 2010 health needs assessment, sponsored by the Paso del Norte Foundation and which serves as primary guidance in forming the Region 15 Regional Health Plan, documented that the area is underserved in 18 of the 24 assessed specialties, and **surgery was the second greatest numerical need**[i]. **There is a need for approximately 50 surgeons in our RHP and more than 95** when including our traditional referral areas including southeastern New Mexico and Juarez.

The situation at the Paul L. Foster School of Medicine mirrors this regional shortage. The average **time to 3rd new patient appointment for the six surgeons that provide general surgery services is 44 days**.
For various process reasons and after a preliminary review of our appointment structure in the Department of Surgery, we are confident this is an underestimate of the true time to 3rd appointment. Part of our DY2 project will be to revise our appointment templates to allow more accurate measurement of this metric. We provide services in a single central clinical location, the Alberta campus, and our referral mechanism is a traditional combination of paper, fax and phone call. We propose to begin to address this need through the hiring of additional general surgeon and surgery physician extender FTE's over the period DY2-5.

For purposes of baseline of the numbers of surgical providers, we consider the baseline to be the number of providers providing general surgery working at the beginning of DY1. For purposes of numbers of unique patients, we will consider the baseline to be an annualized rate based on the last 4-6 months of DY2. It is necessary for us to complete the template redesign process to be sure we accurately count unique patients as general surgery patients.

Challenges: We are proposing to recruit a large number of surgical providers to a region which is highly underserved to care for a low income population. Compensation in our organization does not match that of the private community. The association with a medical school and a surgical residency will mitigate this to some extent.

5 year expected outcome for providers and patients: The performing provider expects to see improvements in access as measured by the time to 3rd new patient appointment to see a surgeon; In addition we will provide outpatient surgery clinic services in at least one additional location to make pre-operative consultation and post-operative care more convenient, and provide evening hours. We will reduce the time to 3rd new appointment for general surgery referrals to 25 days or less.

Each new surgical provider, when established, will provide services to a minimum of 250 unique patients each year. Given the anticipated time frame of CMS approval of this project, and recruitment timelines, the estimated impact for DY2 is 125 unique patients. We estimate, on average, each new surgeon will provide services to a minimum of 125 patients in their first DY, rising to 250 in subsequent years. The total number of unique patients served will be
DY2:125 DY3:375 DY4:500 DY5:875

Rationale: The status of surgical services is particularly acute at the Paul L. Foster School of Medicine. At the present time, the six surgeons who provide some general surgery services, each staff a single half-day clinic every week. The remainder of their clinical time is spent covering hospital inpatient areas, and staffing the region's only level 1 trauma center. General surgery consultations in

the clinic are intermixed with hospital post-operative visits and referrals from emergency departments. The result is that less urgent general surgical referrals are frequently bumped for urgent referrals and those non acute conditions cannot be managed until such time as they become urgent, frequently following presentation to the emergency department.

This situation is exacerbated by a critical shortage of primary care providers in the Region meaning that many patients are not able to exhaust non operative options prior to arriving at a point that operative care is indicated. There is very limited capacity to refer a post-surgical patient for long term care of a chronic condition which may have precipitated the need for surgery. We propose to address this aspect of the problem through a separate project, in which we intend to establish the Kenworthy Family Medicine Clinic as a Primary Care Medical Home. In the face of a geographically distributed provider base, electronic means of communication are critical to achieving efficiencies in the referral process and return to the primary care provider. As part of the infrastructure development for this project, we will investigate, deploy, and utilize an electronic referral system between primary care providers and surgical services within the enterprise. Sharing of a common EMR across our enterprise assures that all clinical information is centralized and available immediately to any provider.

Overall, the existing state of surgical services at PLFSOM represents a state of perpetual crisis, with limited ability to respond to anything but the most urgent of needs. Since surgical services are so scarce and the demand is so great, each surgeon reviews his or her own schedule essentially daily, reviewing consults to try and identify the most urgent. Less urgent patients are routinely bumped for those that are more urgent. This is highly inefficient use of provider and staff time, and disenfranchises many patients yet it is necessary to ensure the most urgent patients are seen. Routine indicated surgical procedures may be deferred for up to 6 months based on surgical availability. Surgical clinic volumes are enormous, typically averaging 35+ patients/ half day.

Geographically, the population of our region is divided into three distinct areas, separated by the Franklin Mountains which split El Paso into the west, central and east areas. Our current clinic location is in the central region, resulting in long drives and difficult access conditions for many patients, particularly for those who depend on public transportation. By establishing at least one additional, geographically distinct, outpatient clinic location, we will be able to provide pre- and post-operative consultation, evaluation, and post-operative care, in a location more readily accessible for many patients. This outpatient clinic is not intended to be an ambulatory surgery clinic.

We propose to address the access and capacity issues through the recruitment of six surgical providers over DY2-5. We anticipate adding four FTE surgeons and two surgery focused physician extenders to the care management team. These providers can, in cooperation with surgeons, provide a full spectrum of pre- and post- operative care including pre-operative histories and physicals as well as post-operative wound checks and dressing changes. By providing a continuum of care providers in a single location, united by a common electronic health care record, we can match patient needs to provider expertise and training, freeing surgeons for the most critical and complex decision making and procedural tasks, thereby increasing throughput.

Project Option 1.9.2 was chosen because it reflects the primary elements of our proposal: more providers in geographically distinct area(s) with extended hours, linked by an e-referral system back to our primary care providers.

We have chosen metrics that reflect 1) the numbers of new surgical providers we recruit to the performing providers faculty 2) the resultant increase in numbers of unique general surgery patients

seen by performing provider, 3) increasing access by establishing a second clinical site to provide general surgery services and making it more convenient, especially for those who cannot readily take off from work for a doctor's appointment by establishing night hours, and 4) the planning, deployment and utilization of an e-referral system which will increase the efficiency of the referral process and optimize utilization of scarce resources.

Taken together, these metrics will provide a comprehensive view of the improvements in access we have achieved by this project and document the increased efficiencies of an electronic referral system.

An electronic referral system is a component of another our proposed projects. In both situations, we anticipate a significant amount of customization work by specialty to assure that all relevant information is provided to determine the urgency of the referral, and minimize the requirements for multiple consultations due to lack of complete patient information and studies.

The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. Depending on the clinical department in question, between 75% and 85% of our population self identifies their ethnicity as Hispanic. The expansion of surgical resources and additional service locations by the Performing Provider represents the best opportunity to integrate care management, primary care, and necessary surgical consultative services through a single provider referral network and the use of a common EMR system to meet well documented unmet needs of our unfunded and Medicaid patient base.

We chose Project Option 1.9.2 because it reflected the most practical way to achieve increased access in the near term.

Project Components: We will meet all required project components.

a. Increase service availability with extended hours: As part of our second clinical site, we will offer evening hours to better meet the needs of patients, particularly those with a limited ability to take off from work to see a physician.

b. Increase number of specialty clinic locations: A core part of this project is to establish a 2nd, geographically distinct site to provide outpatient consultative services.

c. Implement transparent, standardized referrals across the system: We will implement an electronic referral system which will track referral source, data and time of referral and allow for standardized reporting of access times.

d. We will develop a electronic referral request customized to general surgery and train providers and referral sources on the use of this form.. We provide monthly feedback to high volume referral sources on the access times, and completeness and accuracy of these forms and we will review its functionality on a regular basis in our EMR steering committee.

Unique Community Need:

CN.2 Specialty Care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative. This project builds upon an existing base of general surgery capacity within the Performing Provider which is inadequate to meet the needs of our indigent and unfunded population. The components of an additional clinical site, evening hours, and e-referral are entirely new for the organization.

Related Category 3 outcome measures:
OD-6 Patient Satisfaction: **IT 6.2 Other outcome improvement target**

We propose to utilize the RAND VSQ-9 Patient Satisfaction Survey (attachment A) as a stand-alone measure of patient satisfaction. The Performing Provider has experience with Press Ganey survey instruments within the past decade. Overall response rates were very low, in the single digit range. We believe there are a series of structural issues that drove this poor response. Our population is heavily enriched in low income patients. Challenges related to incorrect and changing addresses, and the comprehension level required completing more complex survey tools such as CG-CAHPS limits response rates. Also, our Region shares an international border with Juarez, Mexico. We believe that many patients in our population choose not to respond to such a survey, not fully understanding the importance of their response, and not recognizing that their participation has no impact on their residence in the region. For these reasons we believe a short survey, administered at the point of service, represents the best option to obtain meaningful data across a wide patient representation. The RAND survey has been validated for accuracy and validity [ii] and contains questions which focus on high level patient satisfaction domains and will provide actionable information to improve our regional care delivery. We acknowledge that this survey will not provide results which are directly comparable to CG-CAHPS on a national level. They will, however, provide valid, actionable data on which to assess the impact of this project in Region 15.

Rationale for selecting the outcome measures: Patient satisfaction is a high level indicator of the overall success of our efforts to improve access to surgical services.

Relationship to other projects and measures: This project links to Project Area 084597603.2.1 which is the establishment of the Kenworthy Family Medicine clinic as a primary care medical home. It will be important that many of these patients come from and return to an identified primary care provider to ensure optimal non-surgical management of any associated chronic conditions.

Relationship to other Providers Projects in the RHP: A number of providers are proposing projects to expand access to primary care. We anticipate that this expansion will result in increased demand for surgical services. As such, these projects and ours complement one another for the Region.

Plan for Learning Collaborative: We will participate in RHP sponsored semi-annual learning collaboratives.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the

amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program, as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

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[i] Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

[ii] http://www.rand.org/health/surveys_tools/vsq9.html. Accessed September 29, 2012.

Attachment A

Patient Satisfaction Survey

Thinking about your visit with the physician/health care Professional you aw, how would you rate the following:

	Poor	Fair	Good	Very Good	Excellent
1. How long you waited to get an appointment	O	O	O	O	O
2. Convenience of the location of the office	O	O	O	O	O
3. Getting through to the office by phone	O	O	O	O	O
4. Length of time waiting at the office	O	O	O	O	O
5. Time spent with the physician/health care professional you saw	O	O	O	O	O
6. Explanation of what was done for you	O	O	O	O	O
7. Technical skills (thoroughness, carefulness, competence) of the physician/health care professional you saw	O	O	O	O	O
8. The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw	O	O	O	O	O
9. The visit overall	O	O	O	O	O

084597603.1.5	***1.9.2***	***PROJECT OPTIONS1.9.2 (A-C)***	Expanding access to surgical services to a Hispanic population
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.7	*IT-6.2*	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[I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I -22.1] Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialty (surgery) Goal: Hire one additional general surgeon in DY2 Data Source: HR records demonstrating employment in DY2 Milestone 1 Estimated Incentive Payment: $141,108 **Milestone 2** [P-7]: Complete a planning process/submit a plan to implement electronic referral technology Metric 1 [P-7.2]: Development of an implementation plan for e-referral Goal: Documentation of implementation plan including description of training required, hardware and software needs, and implementation timeframe to establish e-referral functionality from primary care providers to general	**Milestone 8 [I-22]** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I -22.1] Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialty (surgery) Goal: We will increase) Increase staff by 1 over DY2 Data Source: HR records demonstrating employment in DY2 Milestone 8Estimated Incentive Payment: $180,779 **Milestone 9** [P-7]: Complete a planning process/submit a plan to implement electronic referral technology Metric 1 [P-7.1] Complete a planning process/submit a plan to implement electronic-referral technology Goal: Develop, design, implement, and disseminate new staffing plan with regard to e-referrals Data Source: staffing plan	**Milestone 14 [I-22]** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I -22.1] Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: We will increase) Increase staff by 1 over DY3 Data Source: HR records demonstrating employment in DY3 Milestone 14 Estimated Incentive Payment: $297,935.75 **Milestone 15** [P-9]: Implement referral technology and processes that enable improved and more streamlined provider communications Metric 1 [P-9.1]: Baseline/Goal: Implement e-referral technology between Primary care providers in Family Medicine and Internal Medicine, and General surgery program. Data Source: IT documentation Milestone 15 Estimated Incentive Payment: $297,935.75	**Milestone 18 I-22]** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I -22.1] Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: We will increase) Increase staff by 1 over DY4 Data Source: HR records demonstrating employment in DY4 Milestone 18 Estimated Incentive Payment: $383,815 **Milestone 19**[I-23]: Increase specialty care clinic (surgery) volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2] Documentation of increased number of unique patients. Demonstrate improvement over DY3 Baseline/Goal: Performing provider will provide services to 875unique patients. Data Source: Electronic scheduling system reports Milestone 19 Estimated Incentive Payment: $383,815

084597603.1.5	***1.9.2***	***PROJECT OPTIONS1.9.2 (A-C)***	Expanding access to surgical services to a Hispanic population	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.7	*IT-6.2*	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)**
surgery providers. Milestone 2 Estimated Incentive Payment: $141,108 **Milestone 3** [P-X-1]: Initiate a needs assessment and plan for the establishment of a 2nd outpatient surgery clinic site. Metric: Perform needs assessment and create plan Goal: Needs assessment and plan details to be finalized by the end of DY2. Clinic will develop strategic plan for implementation of second surgical clinic site. Data Source: Project Plan Milestone 3 Estimated Incentive Payment: $141,108 **Milestone 4** [P-X-2]: Complete redesign of surgery clinic appointment templates to facilitate tracking time to 3rd next general surgery appointment and number of unique general surgery patients. Metric: Redesign template with 3rd next general surgery appointment tracking system	Milestone 9 Estimated Incentive Payment: $180,779 **Milestone 10** [P-2]: 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 processes, guidelines and technology for referrals and consultations into selected medical specialties. Goal: 80% of staff in general surgery clinic will be trained in referral processes, policies, and technology. Milestone 10 Estimated Incentive Payment: $180,779 **Milestone 11** [P-8]: Develop the technical capabilities to facilitate electronic referral Metric 1 [P-8.1]: Demonstrate technical mechanisms to be used to operate referral system are in place Goal: recruit / assign IT and / or EMR team members to support the roll-out of e-referral as described in the implementation plan developed in Milestone 6 Data Source: Project plan		**Milestone 16** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.2] Increase total number of unique patients encountered in the surgery clinic for DY4 Baseline/Goal: Performing provider will provide services to 500 unique patients. Data Source: Electronic scheduling system reports Milestone 16 Estimated Incentive Payment: $297,935.75 **Milestone 17** [P-11]: Launch/expand a specialty care clinic Metric 1 [P-11.1]: Establish/expand specialty care clinic Goal: Outpatient general surgery services will be available in one additional clinic besides the current Alberta site. Data Source: Appointment schedules for new clinic Milestone 17 Estimated Incentive Payment: $297,935.75	**Milestone 20** [P-X-1]: Increase the number of general surgery referrals that are received by e-referral system. Metric: Increase general surgery referrals Baseline/Goal: The number of e-referrals received to the general surgery clinic will increase by 15% over the annualized number in DY4 Data Source: Project Plan Milestone 20 Estimated Incentive Payment $383,815

084597603.1.5	***1.9.2***	***PROJECT OPTIONS1.9.2 (A-C)***	Expanding access to surgical services to a Hispanic population	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.7	*IT-6.2*	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)**
Goal: Clinic will resign templates, implement, and disseminate information regarding redesign of surgery clinic. Data source: Revised appointment templates Milestone 4 Estimated Incentive Payment: $141,108 Milestone 5 [I-23] Increase specialty clinic volume Metric 1-23.2] Documentation of increased numbers of unique patients. Goal: Performing provider will provide services to 125 unique patients. Data Source: EMR, Scheduling program Milestone 5 Estimated Incentive Payment: $141,108 **Milestone 6** [P-7]: Complete a planning process/submit a plan to implement electronic referral technology Metric 1 [P-7.2]: Develop an implementation plan for e-referral Goal: Documentation of	Milestone 11 Estimated Incentive Payment: $180,779 **Milestone 12** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2] Documentation of increased number of visits. Improvement over DY1 performance over prior reporting period. Goal: Performing provider will provide services to 375 unique patients. Data Source: Electronic scheduling system reports Milestone 12 Estimated Incentive Payment: $180,779 **Milestone 13 [P-21]:** P-21]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement.			

084597603.1.5	***1.9.2***	***PROJECT OPTIONS1.9.2 (A-C)***	Expanding access to surgical services to a Hispanic population	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.7	*IT-6.2*	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)**
implementation plan including description of training required, hardware and software needs, and implementation timeframe to establish e-referral functionality from primary care providers to general surgery providers. Data Source: Implementation plan Milestone 6 Estimated Incentive Payment:$141,108 **Milestone 7 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 7 Estimated Incentive Payment: $141,108	Data Source: Meeting flyers, slides, notes from meetings Milestone 13 Estimated Incentive Payment: $180,779			

084597603.1.5	***1.9.2***	***PROJECT OPTIONS1.9.2 (A-C)***	Expanding access to surgical services to a Hispanic population	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.7	*IT-6.2*	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)**	
Year 2 Estimated Milestone Bundle Amount: $987,756	Year 3 Estimated Milestone Bundle Amount: 1,084,674	Year 4 Estimated Milestone Bundle Amount: $1,191,743	Year 5 Estimated Milestone Bundle Amount: $1,151,445	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $4,415,618				

95691

Project Option 1.1.4 - Expansion of Pediatric primary care by providing Health Periodicity Exams in conjunction with a visit to an acute care walk in clinic

Unique Project ID: 084597603.1.6
Performing Provider Name / TPI TEXAS TECH HS CTR FAMILY MED / 084597603
Project Title: Increasing Utilization of Well Child Exams

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will develop the infrastructure and personnel to provide health maintenance exams in the setting of an existing acute care, walk in clinic to eligible patients presenting for an acute care visit AND to their siblings.

Need for the project: Compliance rates with health maintenance exams (which are fully covered under Medicaid plans) is very low after the first year of life, falling to the high 30% to low 40% range after one year and is in the teens after age 10. The acute care clinic represents a prime target population: 28% of children seen in our existing acute care clinic are eligible for a health maintenance exam, and less than 5% receive the exam in a scheduled setting after the acute care visit. Additionally, more than 80% of the patients utilizing the acute care clinic are older than 2 years of age, precisely the demographic that does not receive routine health maintenance exams in our population.

Target Population**:**
a) Number of patients served: Overall, just applying this program to the index patient (not siblings) represents approximately 2600 unique patients annually.

b) Benefit to Medicaid / Indigent Patients: Over 90% of enterprise pediatric encounters are provided to patients with Medicaid or no 3rd party insurance.

Category 1 or 2 expected benefits: DY 2 will be devoted to planning, identifying and hiring needed resources and developing tracking mechanisms. We will provide the following minimum numbers of Health Periodicity Exams in the acute care setting:
DY2: 0 DY3:400 DY4: 600 DY5:750

Category 3 outcomes: We will focus on immunization status of Hispanic patients eligible to receive the Tdap booster at age 11 years or older. *of children, who self-report ethnicity as Hispanic, who are current in their Tdap booster status at the completion of receiving a health maintenance examination in the acute care setting will be 50% in DY4 and 60% in DY5*

We can not provide an absolute number of patients who will receive this vaccine since it a function of how many children in the eligible age range access services, and don't already have the vaccine from another source.

New initiative or enhancement /expansion of an existing initiative: This is a new initiative being provided in the setting of an existing acute care, walk in clinic.

Goal: The goal of this project is to increase the number of children who receive appropriate health periodicity exams as defined by the American Academy of Pediatrics Bright Futures Recommendations and are current in their immunization status.

Description: Completion of nationally recommended preventive pediatric health care (Periodicity) examinations in our population is challenging at all age ranges, and particularly after the 12 month visit. A number of reasons may contribute to this including parental perceptions that "everything is all right", transportation challenges, or the need to take off work and remove the child from school or day care. In addition, a significant number of our patients access care on both sides of the border and may believe that they have received an equivalent service in Juarez. The result is that a significant number of patients with Medicaid funding to cover the entire cost of preventative care do not utilize this service. Instead, they access care on an "as needed" basis through acute care services. Motivating parents and caregivers to access preventative screening examinations services is challenging even when the cost is entirely borne by federal or state programs.

The populations we most commonly serve, Hispanics with low household educational and higher levels of poverty, at are particular risk of not receiving health maintenance exams.[v] Eighty-nine percent of the patients we treat in our after-hours acute care walk in clinic are uninsured, or have Medicaid or CHIP as a payor.

We propose to utilize a "just in time" delivery model to offer periodic health exams visit to all eligible children in the family of an index patient who presents to the walk in clinic. This approach has been successful in a Medicaid population in Oklahoma[vi]. We do not intend to supplant the traditional provider – patient relationship where one exists and the parent is regularly accessing preventative care. Rather we are identifying children who have fallen off the recommended pathway, are not receiving services they are eligible for, and use the acute care visit as opportunity to both provide the screening examination and try to reestablish the patient with a Primary Care Provider for subsequent exams. Re-establishing such a relationship may result in the child receiving future recommended periodicity exams and also reduced use of acute care services in the future.

Challenges: The major barrier will be overcoming parental perceptions that the health maintenance examinations of older children are not important and not worth the time. We

propose to overcome this by offering a token incentive (a $10 visa gift card) to the parent for each child including the index patient who completes a due health maintenance examination in conjunction with the acute care visit.

The process milestones chosen for this project reflect the planning, integration with IT and EMR to develop reporting capabilities, and training of staff as well as the development of informational literature, and to establish baseline rates for the improvement targets in this project as well as its associated Category 3 targets. We have chosen a single outcome measure, I- 15.3: Documentation of increased number of unique patients. We define a unique patient as a patient <=18 years of age, who receives a preventative service in the acute care billing area (CPT 99381-99384, 99391-94), and has none of these codes billed in the preceding 6 months. By measuring the number of unique patients, we identify children who are not accessing preventative health care.

Relationship to Regional Goals: This project will address the Region's goal of overcoming language, socio-economic, and monetary barriers to accessing care as well as enhancing the Region's ability to provide a continuum of healthcare services.

Expected 5 year Outcome: At the end of DY5, we will have fully integrated well child visits as a service offered to those who seek acute care, and improved the % of patients who are current with recommended periodicity exams and immunization status

Rationale:

Baseline: Paul L. Foster School of Medicine Department of Pediatrics provides day, evening and weekend hours walk in acute care services in an effort to reduce inappropriate ED visits in this population. Our proposal is to expand the capabilities of this acute care clinic to provide health maintenance screening, exams and immunizations. This strategy will overcome many of the barriers to completion of these exams in older infants and children: Acute care is a walk-in service; therefore parents are motivated to access care as it is needed. The transportation and work /day challenges have been met through extended hours of availability of services. Acute care services are available weekdays from 8AM to 10PM, and Saturdays from 10AM-4PM. From a cultural perspective, healthcare in our region is a family event. It is not unusual to see two or three siblings in the waiting room with the index patient. This "just in time" strategy presents an opportunity to screen the siblings as well for a needed health maintenance exam, and if necessary, offer it at that point AND connect the parent and child with a primary care provider going forward.

Using data from our largest Medicaid provider, El Paso First, the percentage of children receiving the 12 month well child exam is approximately 43%, and drops to 23% for the 1.5 year

exam. Even for younger children, compliance with recommended exam schedules is poor. As a general rule, participation in the first 6 months of life is only in the high 50% range. In older children the participation worsens, falling to the high 30% to low 40% range after one year and is in the teens after age 10. In this scenario, issues such as hearing loss or vision difficulties are frequently not identified until the child enters school and is struggling.

We do not believe the driving issue is access to providers or insurance. The 2010 Paso del Norte Foundation region wide planning symposium addressing and documenting health care needs in a broad area which includes Region 15, and which serves as the basis for our Region's needs assessment, found no shortage of primary care pediatricians[vii]. Essentially every pediatric patient presenting for scheduled well child care is insured with at least a Medicaid level coverage and we, as well as the overwhelming majority of pediatricians in our region are Medicaid providers.

There is a significant opportunity in our patient population to benefit from this project. Our Alberta based acute care program provides more than 9500 visits / year through daytime, evening and weekend services. A pilot study from April – June 2012 demonstrated that 28% of patients seen were due and eligible for a periodic health Maintenance examination. Of the eligible population, only 14% received the exam in conjunction with the acute care visit, largely related to availability of provider time and / or vision and hearing screening resources. Of the children eligible who did not receive the exam at the time of the acute care visit, less than 5% subsequently returned to receive the recommended examination. Furthermore, eighty percent (80%) of the patients seen through our acute care program are older than 2 years of age, precisely the demographic that does not access routine health maintenance exams. Overall, just applying this program to the index patient provides represents approximately 2600 unique patients. The potential population at risk, and who may benefit from this intervention, is substantially greater, since we were only able to determine need for a periodicity exam on children who were the index patient, not on accompanying family members.

The process we propose is straightforward. Parents of children presenting to the acute care clinic and whose insurer provides a portal for determining the status of their well child visit (all Medicaid and managed Medicaid products), will be informed of the project. If the parent declines participation, the index patient will be seen for their acute care visit as usual. If the parent chooses to participate, we will ask for the demographics of any accompanying children. Staff will query the insurer database and IMTRAC, our state wide, vaccine registry and we will provide all elements of the Healthy Steps Periodicity Exam, including immunizations, hearing and vision screening, as required for that age.

This project has the potential to improve the utilization rates of preventative, health screening and maintenance exams in a population burdened with significant healthcare disparities, as 94% of the patients seen in the acute care program self-identify as Hispanic ethnicity. Over 90% of

the patient visits in Pediatrics this fiscal year have been provided to patients with Medicaid or no insurance.

Project Components: We chose Project option 1.1.4 as the best description of our proposal. Our proposal represents a unique approach to addressing the challenge of poor use of preventative and screening services in an at risk population.

Community Need: This project addresses the Community Need CN.1, expanding primary care.

Starting Baseline: We will establish a baseline for the number of health maintenance exams done in the acute walk in clinic by tracking data from the last three months of DY2 and annualizing it. This will give us sufficient time to complete Milestone 1, the planning process for the required metrics.

This project represents a significant enhancement to our existing acute care walk-in clinic, and leverages existing space and staff commitments to enhance primary care preventative services.

Related Category 3 outcome measures.

OD-11 Addressing Health Disparities in Minority Populations

> IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure*) *% of children, age≥ 11 years,who self -report ethnicity as Hispanic, who are current in their Tdap booster status at the completion of receiving a health maintenance examination in the acute care setting.*

Up to date vaccination is an essential component of preventative health care for children. It is not unusual to find children who are significantly deficient in vaccinations only identified until they attempt to enroll for school or are hospitalized[viii]. Given the drop off in utilization of health maintenance exams after 15-18 months, this becomes a significant area of potential risk mitigation, and would be addressed by this metric. Moreover, El Paso County is experiencing an epidemic of pertussis, making the booster immunization all the more important.

Relationship to Other Projects and Measures: This project stands alone with respect to our portfolio of projects, based on a unique need in the pediatric population

Relationship to Other Performing Providers Projects: A number of other providers are addressing the need for increases in primary care and wellness in the region.

Plan for Learning Collaborative We will participate in the RHP sponsored learning collaborative.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones

of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

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[i] Lo KM, Fulda KG., Osteopath Med Prim Care. 2008 Dec 8;2:12.

[ii] Smith KD, Merchen E, Turner CD, Vaught C, Fritz T, Mold J.., J Okla State Med Assoc. 2010 Jul; 103(7):248-53.

[iii] Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

[iv] Kum-Nji P, James D, Herrod HG., Pediatrics. 1995 Sep;96(3 Pt 1):434-8

084597603.1.6	***1.1.4***	***PROJECT OPTION 1.1.4***	Expansion of Pediatric primary care by providing Health Periodicity Exams in conjunction with a visit to an acute care walk in clinic
TEXAS TECH HS CTR FAMILY MED			*084597603*
Related Category 3 Outcome Measure(s):	*084597603.3.8*	***IT-11.1***	The impact of expanding access to Health Periodicity Exams on immunization status in a Hispanic 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 [P-X -1]: Complete the planning process for this project, Metric P-X.1 Complete infrastructure preparation, staff training, and patient information including patient information sheets, IT and EMR integration, and designing of reports Data Source: Planning Document, Patient information sheets, sample reports. Milestone 1 Estimated Incentive Payment *(maximum amount):* $112,500 **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 1 [P-5-1]: Documentation of increased number of providers and staff and/or clinic sites. Data Source : HR records, Project plan. Milestone 2 Estimated Incentive Payment *(maximum amount):* $112,500 **Milestone 3** [P-X -2]: Establish baseline number of unique patients.	**Milestone 5** [-I-15-3]: Increase access to primary care capacity. Metric 1 [I-15.3]: Documentation of increased number of unique patients. Goal: We will increase the number of unique patients who receive a Health Maintenance Exam in the walk in-clinic to 400 Data Source: EMR, Electronic Scheduling Milestone 5 Estimated Incentive Payment: $225,000 **Milestone 6** [**CQL** -P-3]: Quality Improvement Milestone Metric 1[CQL P-3.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Data Source: attendance records, copies of presentations made. Milestone 6 Estimated Incentive Payment: $225,000	**Milestone 7** [-I-15-3]: Increase access to primary care capacity Metric 1 [I-15.3]: Documentation of increased number of unique patients. Goal: We will increase the number of unique patients who receive a Health Maintenance Exam in the walk-in clinic to 600 Data Source: EMR, Electronic Scheduling Milestone 7 Estimated Incentive Payment: $225,000 **Milestone 8** [**CQL** -P-3] Quality Improvement Milestone Metric 1[CQL P-3.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Data Source: attendance records, copies of presentations made. Milestone 8 Estimated Incentive Payment: $225,000	**Milestone 9** [-I-15-3]: Increase access to primary care capacity Metric 1 [I-15.3]: Documentation of increased number of unique patients. Goal: We will increase the number of unique patients who receive a Health Maintenance Exam in the walk-in clinic to 750 Data Source: EMR, Electronic Scheduling Milestone 9 Estimated Incentive Payment: $217,391 **Milestone 10** [**CQL** -P-3] Quality Improvement Milestone Metric 1[CQL P-3.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Data Source: attendance records, copies of presentations made. Milestone 10 Estimated Incentive Payment: $217,390

084597603.1.6	***1.1.4***	***PROJECT OPTION 1.1.4***	Expansion of Pediatric primary care by providing Health Periodicity Exams in conjunction with a visit to an acute care walk in clinic	
TEXAS TECH HS CTR FAMILY MED				*084597603*
Related Category 3 Outcome Measure(s):	*084597603.3.8*	***IT-11.1***	The impact of expanding access to Health Periodicity Exams on immunization status in a Hispanic 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)**
Metric [P-X-2.1] Establish a baseline rate for the number of unique patients who receive a health maintenance exam in the acute care walk in c clinic. This will be an annualized number based on the last 3 months of DY2 Data Source: EMR, Scheduling system, billing reports. Milestone 3 Estimated Incentive Payment *(maximum amount):* $112,500 **Milestone 4** [**CQL** -P-3] Metric 1[CQL P-3.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: attendance records, copies of presentations made. Milestone 3 Estimated Incentive Payment: $112,500				
Year 2 Estimated Milestone Bundle Amount:$450,000	Year 3 Estimated Milestone Bundle Amount: $450,000		Year 4 Estimated Milestone Bundle Amount: $450,000	Year 5 Estimated Milestone Bundle Amount: $434,783
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,784,782				

95695

Project Option 1.9.1 - Increased access to minimally invasive surgical (MIS) services for low income and Hispanic patients

Unique Project ID: 084597603.1.7
RHP Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603
Project Title: - Increased access to minimally invasive surgical (MIS) services for low income and Hispanic patients

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will support the establishment of a two minimally invasive surgery fellowship.

Need for the project: This project will address a critical shortage of surgical providers in our region, and the limited availability of surgeons trained in minimally invasive techniques. There is only a single fellowship trained MIS surgeon on the full time faculty of the performing provider. Hispanic women, who represent the majority of our female patient population, are in particular need of this service because 1) they have higher rates of diagnosis for fibroid tumors, a leading cause for performance of hysterectomy which is among the most common indications for a MIS procedure, and 2) compared with white women, Hispanic women have higher lengths of stay and costs per day when undergoing open procedures.

Target Population: Our patient population is overwhelmingly Hispanic, and given that 60% of our ambulatory encounters are to patients with Medicaid or no insurance, this project will be a direct benefit to that population.

Category 1 or 2 expected benefits : Fellowships typically begin in July whereas the DY calendar begins in October. This is reflected in the numbers of patients served DURING THE WAIVER. The impact of this program will continue beyond the waiver period.

Unique Patients served:
DY2: 35 DY3: 100 DY4: 120 DY5:140

The total value of this project is not solely in the number of patients seen, but in the establishment of a fellowship training program. Such training represents the best long term solution to develop a pipeline of providers for the region. The establishment and support of a fellowship program requires a substantial commitment of provider and fellow's time to non direct patient care activities.

Category 3 outcomes: The outcomes chosen are OD-14 Workforce projects, including
IT – 14.4 Percent of graduates who practice in a HPSA or MUA
IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

These outcomes were chosen because they reflect the impact of support of these training programs on the population barriers targeted by the 1115 Waiver program: low income and low access to care.

At the end of DY5, we anticipate there will be two graduates of this fellowship. 50% of the graduates at the end of DY5 will have meet IT-14.4, 14.7 and 14.8

New initiative or enhancement /expansion of an existing initiative: This is a new initiative as a training program for MIS does not exist in the Region at this time.

Project Description:

Project Goals: The overall goal of this project is to increase the availability of minimally invasive surgical techniques to a Hispanic and low income population by leveraging our existing faculty resources to develop an accredited two year fellowship program in Minimally Invasive Surgery (MIS).

Challenges: Surgical care in Region 15 is in a state of crisis. A 2010 health needs assessment, sponsored by the Paso del Norte Foundation and which serves as primary guidance informing the Region 15 Regional Health Plan, documented that the area is underserved in 18 of the 24 assessed specialties and **surgery was the second greatest numerical need** (1). **There is a need for approximately 50 surgeons in our RHP and more than 95** when including our traditional referral areas including southeastern New Mexico and Juarez. Through the use of minimally invasive techniques, hospitalization times may be reduced and costs lowered (2, 3). The population served by the PLFSOM has limited access to these services: We have a single full time faculty member who is fellowship trained in minimally invasive techniques, and his practice is predominately oncology in nature. The time to 3rd new Gynecology appointment for this provider is currently 35 days. Another provider has some experience with MIS and performs them in some women, but is not fellowship trained. In the face of severe shortages of surgical services in the Region, low income and uninsured women have very few options apart from the PLFSOM for these vital services. Seventy percent (70%) of our population either lack 3rd party insurance coverage, or have only Medicaid. Hispanics, whom represent the overwhelming majority of our patient population, may have increased needs for MIS techniques.

The Hispanic population has a higher rate of diagnosis for fibroid tumors than Caucasian women, a leading cause for performance of hysterectomy (4) which is among the most common indications for an MIS approach. Moreover, compared with white women, Hispanic women have higher lengths of stay and costs per day when undergoing open procedures (5). Thus, the

lack of access to this technique represents a significant healthcare disparity to our population.

We propose to begin to address this need by establishing a fellowship (MIS) sponsored in the Department of Obstetrics and Gynecology and accredited by the American Association of Laparoscopic surgeons, the only accrediting body for this fellowship. This fellowship will last 2 years after completion of the standard OB-Gyn fellowship, and enroll one fellow per year. PLFSOM has the required faculty resources to establish an accredited two year training program in MIS in a relatively brief time frame. This project will be conducted in two hospital facilities in our Region, University Medical Center and Las Palmas Medical Center. Both facilities are participating providers in our RHP.

Since most West Texas medical residents stay within a 75 mile radius of their training site to set up practice (6), we have high confidence that the trainees from this program will remain in the region. As such, a MIS fellowship represents the single best way to address, in a sustainable manner, the provider base necessary to meet our region's needs, and also addresses a core reason for the lack of minimally invasive approaches to gain wide spread adoption in the Region among both academic and private providers.

We chose two improvement targets for this project: IT-31 Increase TSC training and/or rotations and IT-23 Increase specialty care clinic volume of visits. The fundamental approach we are proposing to address the critical access issue for MIS services is to develop a training program in this field. As such, the number of trainees, and the number of patient visits they provide, represents a basic measure of the success of this program.

The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. The expansion of minimally invasive surgical resources by the performing represents the best opportunity to integrate care management, primary care and necessary surgical consultative services through a single provider referral network and EMR to meet well documented needs of our unfunded and Medicaid patient base.

Relation to Regional Goals: This project addresses several regional goals by enhancing the region's ability to provide disease management, increasing the numbers of specialists and scope of services offered in the region, and by assisting patients to overcome socio-economic barriers to accessing care.

5-year expected Outcome for Providers and Patients. At the end of DY5, the Region will have an accredited two year fellowship program in MIS and will have graduated two fellows from the program. We will be able to document an increase in the number of women receiving surgical procedures utilizing MIS techniques by the performing provider.

Baseline / starting point: A fellowship does not exist at this point, so the baseline number of fellows is zero. For purposes of measuring the number of patient who receive an MIS procedure, we will use a number annualized from January to June of DY2.

Rationale:

We chose project option 1.9.1 because we have already identified this area as a high impact area, and had identified the creation of a fellowship program as the most likely means to secure, in the long term, and adequate supply of physicians offering this service.

Project Components:

a. Identify high impact/most impacted specialty services and gaps in care and coordination. We have accomplished this during DY1, as part of the justification for establishing the fellowship. This was based on the limited number of faculty available on our campus to provide this service to indigent, low income and Hispanic women. In particular, the lack of a fellowship trained Gynecologist providing this service for non-oncologic care was felt to be significant given the uterine fibroid and delayed healing after open procedures for Hispanic women.
b. Increase the number of residents/trainees choosing targeted shortage specialties. This is a core component of the project.
c. Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention). As noted in our narrative, we have received expressions of interest from several of our affiliated hospitals supporting this initiative. Each recognized the difficulty of attracting highly trained providers to such an under-served region. We believe that a fellow that completes his or her training in Region 15 is likely to stay in the area, and we have no doubt that positions will be available.

We will address quality improvement opportunities in this project through the documentation of supervision required of a resident in training as well as participating in semi-annual regional learning collaboratives sponsored by the RHP.

The major barrier to this proposal has been identifying funding support for the fellows as well as the required faculty support. In anticipation of this waiver, we have begun, in DY1, significant work on establishing the framework for this project and have high confidence that this project will be successful. We have received expressions of interest from our major hospital affiliates, and have completed and submitted the required supporting documentation. We anticipate accreditation in time to accept our first fellow in July of DY2.

This project addresses community needs CN.2 Secondary / Specialty care .

How the project is a new initiative: This will represent the first and only MIS fellowship in Region 15 and as such is a new initiative. The performing provider has begun the steps

necessary to establish the program in DY1 in anticipation of approval of this DSRIP project to support the endeavor.

Related Category 3 Outcomes Measures:

Relationship to Other Projects and Measures: A number of providers in the Region are proposing significant expansions of primary care services. We anticipate that this increased access will drive increasing requests for evaluation and treatment of conditions which may be addressed through an MIS procedure.

Plan for Learning Collaborative: We will participate in semi-annual Learning Collaboratives sponsored by the RHP.

Value: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

1. Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.
2. J Minim Invasive Gynecol. 2009 Sep-Oct; 16(5):581-8. Open abdominal versus laparoscopic and vaginal hysterectomy: analysis of a large United States payer measuring quality and cost of care. Warren L, Ladapo JA, Borah BJ, Gunnarsson CL.
3. Obstet Gynecol. 2012 Apr; 119(4):717-24. Outcomes and cost comparisons after introducing a robotics program for endometrial cancer surgery. Lau S, Vaknin Z, Ramana-Kumar AV, Halliday D, Franco EL, Gotlieb WH.
4. Am J Obstet Gynecol. 2011 Nov; 205(5):492.e1-5. Epub 2011 Jul 20. Leiomyoma-related hospitalization and surgery: prevalence and predicted growth based on population trends. Wechter ME, Stewart EA, Myers ER, Kho RM, Wu JM.

5. Journal of Health Care Finance 2007; 33(3): 1-16. National Trends and Determinants of Hospitalization Costs and Lengths-of-Stay for Uterine Fibroids Procedures. Becker, E.R., PhD
6. Texas Tech University Health Sciences Center Factbook. Sixteenth ed December 2008.

084597603.1.7	1.9.1	***PROJECT COMPONENT 1.9.1 (A-C)***	***INCREASED ACCESS TO MINIMALLY INVASIVE SURGICAL (MIS) SERVICES FOR LOW INCOME AND HISPANIC PATIENTS***
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.9 084597603.3.10 084597603.3.11	IT- 14.4 IT-14.7 IT-14.8	Percent of graduates who practice in a HPSA or MUAPercent of trainees who report that they plan to practice in HPSA's or MUA's based on a systematic surveyPercent of trainees who report that they plan to serve Medicaid populations based on a systematic 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)**
Milestone 1 [P-14]: Expand Specialty Care Capacity Metric 1 [P-14.1]: Expand the TSC residency... Goal: Creation of a targeted specialty training program in minimally invasive surgery Data Source: affiliation agreements / and or letters of support from PP and participating hospitals. Milestone 1 Estimated Incentive Payment: $110,049.60 **Milestone 2** [P-X]: Obtain approval from the Society of Gynecologic Surgeons to increase the number of TSC residents. Metric 1 [P-.X.1]: Obtain approval to establish a MIS fellowship sponsored by PP. Approval will be obtained from Society of Gynecologic Surgeons who accredits this fellowship, not ACGME. Goal: accreditation approval	**Milestone** 6[I-31] Increase TSC training and/or rotations. Metric 1 [I-31.1]: Increase the number of TSC residents. Goal: Increase number of trainees by 100% from DY2 (two trainees). Data Source: HR records, PP GME office documentation Milestone 6 Estimated Incentive Payment: $201,404 **Milestone 7**[P-21] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings.	**Milestone** 9[I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased numbers of unique patients. Goal: The TSC residents will provide services to a minimum of 120 unique patients Data Source: HR records, PP GME office documentation Milestone 9Estimated Incentive Payment: $323,199 **Milestone 10**[P-21] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides,	**Milestone** 11[I-31] [I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased numbers of visits. Goal: The TSC residents will provide services to a minimum of 140 unique patients Data Source: HR records, PP GME office documentation Milestone 11 Estimated Incentive Payment: $312,270 **Milestone 12**[P-21] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides,

084597603.1.7	1.9.1	***PROJECT COMPONENT 1.9.1 (A-C)***	***INCREASED ACCESS TO MINIMALLY INVASIVE SURGICAL (MIS) SERVICES FOR LOW INCOME AND HISPANIC PATIENTS***
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.9 084597603.3.10 084597603.3.11	IT- 14.4 IT-14.7 IT-14.8	Percent of graduates who practice in a HPSA or MUAPercent of trainees who report that they plan to practice in HPSA's or MUA's based on a systematic surveyPercent of trainees who report that they plan to serve Medicaid populations based on a systematic 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)**
Data Source: Letter of accreditation from SGS, Milestone 2 Estimated Incentive Payment: $110,049.60 **Milestone 3** [I-31] Increase TSC training and/or rotations. <u>Metric 1 [I-31.4]:</u> Increase the number of TSC trainees, as measured by…absolute number Goal: Increase TSC trainees from zero to one. Data Source: HR records, PP GME office documentation Milestone 3: Estimated Incentive Payment: $110,049.60 **Milestone 4** [P-21] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers. <u>Metric 1</u> [P-21.1]: Participate in semi-annual face-to-face meetings or	Milestone 7 Estimated Incentive Payment: $201,404 **Milestone** 8[I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1 [I-23.2]:</u> Documentation of increased numbers of unique patients. Goal: The TSC residents will provide services to a minimum of 100 unique patients Data Source: HR records, PP GME office documentation Milestone 8 Estimated Incentive Payment: $201,404	notes from meetings. Data Source: Meeting flyers, slides, notes from meetings Milestone 10 Estimated Incentive Payment: $323,199	notes from meetings. Milestone 12 Estimated Incentive Payment: $312,270

084597603.1.7	1.9.1	***PROJECT COMPONENT 1.9.1 (A-C)***	***INCREASED ACCESS TO MINIMALLY INVASIVE SURGICAL (MIS) SERVICES FOR LOW INCOME AND HISPANIC PATIENTS***	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.9 084597603.3.10 084597603.3.11	IT- 14.4 IT-14.7 IT-14.8	Percent of graduates who practice in a HPSA or MUAPercent of trainees who report that they plan to practice in HPSA's or MUA's based on a systematic surveyPercent of trainees who report that they plan to serve Medicaid populations based on a systematic 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)**
seminars organized by the RHP. Goal: Performing Provider will sponsor (or participate in RHP sponsored) semi-annual meetings open to other providers, referral sources, and the RHP to identify opportunity for improvement. Data Source: Meeting flyers, slides, notes from meetings. Milestone 4 Estimated Incentive Payment: $110,049.60 **Milestone 5** [I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased numbers of unique patients. Goal: The TSC residents will provide services to a minimum of 35 unique patients Data Source: HR records, PP GME office documentation				

084597603.1.7	1.9.1	***PROJECT COMPONENT 1.9.1 (A-C)***	***INCREASED ACCESS TO MINIMALLY INVASIVE SURGICAL (MIS) SERVICES FOR LOW INCOME AND HISPANIC PATIENTS***	
TEXAS TECH HS CTR FAMILY MED				084597603
Related Category 3 Outcome Measure(s):	084597603.3.9 084597603.3.10 084597603.3.11	IT- 14.4 IT-14.7 IT-14.8	Percent of graduates who practice in a HPSA or MUAPercent of trainees who report that they plan to practice in HPSA's or MUA's based on a systematic surveyPercent of trainees who report that they plan to serve Medicaid populations based on a systematic 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)**
Milestone 5 Estimated Incentive Payment: $110,049.60				
Year 2 Estimated Milestone Bundle Amount: $550,248	Year 3 Estimated Milestone Bundle Amount: $604,242		Year 4 Estimated Milestone Bundle Amount: $646,398	Year 5 Estimated Milestone Bundle Amount: 624,540
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,425,428				

Project Option 1.9.1 Expand Specialty Care: A proposal to expand a Child Psychiatry Fellowship Program

Unique Project ID: 084597603.1.8 Pass 2
Performing Provider Name / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Project Title: Expansion of a Child Psychiatry Fellowship

Project Summary:

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. These patients will benefit directly from this proposal if funded. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will increase the number of child psychiatry fellows accepted for training.

Need for the project: Behavioral health is in a state of crisis in our Region. Most of Texas is designated as a Health Professions Shortage Area for mental health; however the ratio of child psychiatrists to population in our region is less than 20% of the statewide average. A minority of psychiatrists in our Region accept Medicaid

Target Population:

a) The program will provide services to following minimum numbers of unique patients each DY:

DY2: 400 DY3:500 DY4:500 DY5: 600

b) Benefit to Medicaid / Indigent Patients: Given that 60% of our enterprise ambulatory encounters are to patients with Medicaid or no insurance, this project will be a direct benefit to that population.

Category 1 or 2 expected benefits: The number of targeted specialty trainees by 33%. This program will graduate an estimated 7 child psychiatrists by the end of DY5.

Category 3 outcomes: There will be a 20% improvement in the number of trainees who have spent at least 5 years living in, or plan to practice in a HPSA or MUA, a 20% improvement in the number of trainees who report they plan to serve the Medicaid population

New initiative or enhancement /expansion of an existing initiative: This project represents the expansion of an existing initiative to increase the number of behavioral health providers in our region.

Description:

Project Goal: The overall goal of this project is to address a critical lack of behavioral health providers in our region. We propose to accomplish this through the expansion of an existing 2 year child fellowship program from one fellow per year to two fellows per year.

Challenges:

Significant funding is required to expand this fellowship. The existing fellowship is funded with internal startup funding from the performing provider. It is not supported by Federal funding through Medicare Direct Graduate Medical Education funds or any other external source. Patient revenues do not come close to supporting the existing fellow, much less an expansion of the program. In addition, the very high percentage of Medicaid and patients without 3rd party coverage in our practice, and in the Region, makes it extraordinarily difficult to recruit and retain behavioral health providers. This project will address both challenges: 1) by providing secure funding for the fellowship, its continuation can be assured the Region may attract Faculty who wish to be part of a training program, and 2) providers are more likely to stay near the area they have finished training. This 'grow our own' strategy is the single best approach to addressing the critical shortage of behavioral health providers in the long term.

Relationship to Regional Goals: This project meets the regional goals of increasing the number of specialists and scope of services offered in the community, overcoming language, socio-economic, and monetary barriers to accessing healthcare resources in the region, and to better manage patients with chronic diseases.

Expected 5 year outcome for providers and patients:

At the end of DY5, we anticipate having a fully accredited 2 year child psychiatry fellowship accepting two fellows per year, and will have graduated seven additional child psychiatrists as a result of this project

Baseline: The baseline for this program will be December 2011. At that point, there was one child psychiatry fellow in the program.

Behavioral Health services in El Paso are profoundly limited. Currently El Paso County has 0.1 psychiatrists per 100,000 people paralleling a statewide shortage: Only a handful of counties in the state have more than 12 psychiatrists per 1000 and none of these are on the U.S.-Mexico border.

The Texas Department of State Health Services data shows that there are 1,687 psychiatrists in Texas. Only 188 of those are child psychiatrists. Most of those are concentrated along the 1-35 corridor from Bexar County to Dallas County and also in the Harris and Cherokee County areas. El Paso County, like most of Texas, is designated by the US Department of Health &

Human Services as a Health Profession Shortage Area (HPSA) for mental health primarily due to the ratio of psychiatrists to the population.

The availability of child psychiatrists, a subspecialty of psychiatry that involves treatment of children and adolescents with psychiatric disorders, is extremely limited in our Region. Currently, through the El Paso Medical Society, we have verified only three child psychiatrists in the area (although there are several others practicing at Beaumont but that is a closed system). The U.S. Census Bureau estimates that, in 2011, 29.7% of the El Paso population were under the age of 18, making an effective ratio of child and adolescent psychiatrists to youth of 3/243,774 = 1.2 child and adolescent psychiatrists per 100,000 youth. In comparison, the State of Texas (which faces it's own shortage at the state level of child and adolescent psychiatrists), averages 6.5 child and adolescent psychiatrists per 100,000 youth. Child and adolescent psychiatrists serving the El Paso community and surrounding regions are thus in a severe shortage and many children and adolescents are thus not able to receive the services needed, leading to untreated and worsening conditions.

Compounding the issue for El Paso is the fact that our population is primarily Hispanic and poverty rates are higher than the national average. Prior to the establishment of our child and adolescent psychiatry fellowship program at the Paul L. Foster School of Medicine, there were no training programs for child and adolescent psychiatrists in the country along the U.S.-Mexico border. Our program trains and teaches future child and adolescent psychiatrists to work with this special population and the unique cultural issues pertinent to a Hispanic population.

The ability to serve patients who rely on Medicaid to support their healthcare is even more limited. State DSHS figures show that only 3 psychiatrists in the community are currently accepting patients with Medicaid as their payor. Only two child/adolescent psychiatrists in town accept Medicaid patients, and their wait lists for these patients are extremely long.

The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance.

Rationale:

Project Components: We chose project option 1.9.1 Expand high impact specialty care capacity in most impacted medical specialties. This option most directly reflects our proposed approach to addressing a critical shortage of behavioral health professionals in our region.

1) Identify high impact/most impacted specialty services and gaps in care and coordination

a) We have already identified behavioral health services as a high impact provider shortage issue, and this position is supported by the findings of the Paso del Norte Blue Ribbon Committee Regional Strategic Framework Needs Assessment published in 2011 which forms the basis of our Region's needs assessment

2) Increase the number of residents/trainees choosing targeted shortage specialties
- This project will increase the number of residents training in child psychiatry

3) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)
- We believe the positive experience residents will have working as a part of a larger program, as opposed to being the only resident in the program, will result in a more positive experience. In addition, the recent opening of El Paso Children's Hospital, a separately licensed facility dedicated to the care of children, will provide a major incentive for graduating residents to stay in the area.

Furthermore, since most West Texas medical residents stay within a 75 mile radius of their training site to set up practice, an expansion of the existing child psychiatry fellowship represents the single best way to expand the provider base to meet our region's needs.

4) Conduct quality improvement for project
- The Performing Provider will conduct quality improvement activities as part of the expanded residency programs. We will conduct monthly department meetings to monitor the successful implementation, which will be supplemented by our regional meetings. The regional monthly meeting will allow providers to discuss similar project, share best-practices, and get input on how to most effectively improve the delivery system.

The metrics we have chosen for our milestones reflect specific steps required to accomplish an expansion of the residency program, and to reflect the impact the expansion has had on numbers of patients served.

Community Need: This project reflects CN.5: Behavioral health

How does this project reflect a new initiative or a significantly enhances an existing initiative. This project significantly enhances an existing program in that it doubles the number of residents in the program.

Related Category 3 Outcomes

OD-14 Workforce Projects

IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA), or medically underserved area (MUA)

IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Relationship to Other Projects and Measures: This project is related to the Performing Provider project 084597603.1.7 which expands training in minimally invasive surgery, reflecting an organizational priority to increase access through the creation / expansion of GME training programs.

Relationship to Other Providers' Projects in the RHP: Project ID 127376505 1.2 proposed by Emergence Health Network intends to implement strategies to encourage behavioral health providers to serve medically indigent patients. Our proposal directly relates to this through clinical service provided as part of the training process, and potentially as these residents graduate and remains in the area. In addition, is complementary to UMC's project 138951211.1.1. Collectively these represent a coordinated regional approach to the challenges of provider shortages through coordinated increases in the training slots.

Plan for Learning Collaborative: We will participate in the Region's learning collaborative.

Project Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

1. Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

2. Texas Tech University Health Sciences Center Factbook. Sixteenth ed Decembe 2008.

"The Continuing Shortage of Child and Adolescent Psychiatrists." Tomas CR and Holzer CE. J. Am. Acad. Child Adolesc. Psychiatry 2006; 45: 1-9.

“Shortage of Child and Adolescent Psychiatrists in Texas” The Journal of Texas Medicine March 2010

“Highlights: The Supply of Mental Health Professionals in Texas – 2010” Department of State Health Services – The Center for Health Statistics Health Professions Resource Center. April 2011 Publication No. 25-12347

084597603.1.8 Pass 2	***1.9.1***	***1.9.1(A-D)***	A proposal to expand a Child Psychiatry Fellowship Program
TEXAS TECH HS CTR FAMILY MED			*TPI: 084597603*
Related Category 3 Outcome Measure(s):	084597603.3.15 Pass 2 084597603.3.16 Pass 2 084597603.3.17 Pass 2	*IT-14.6* *IT-14.7* *IT-14.8*	*Percent of trainees who have spent at least 5 years in a HPSA or MUA* *Percent of trainees who report they plan to practice in HPSA or MUA* *Percent of trainees who report they plan to serve Medicaid populations.*

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 1 [P-14.1]: Expand the TSC residency, mid-level provider (physician assistants and nurse practitioners), and/or other specialized clinician/staff training programs and/or rotations. Baseline / Goal: The number of TSC in the program will increase from three to 4 by increasing the PGY-1 class to two fellows. Data Source: Documentation of applications and agreements to expand training programs Milestone 1 Estimated Incentive Payment: $65,332 **Milestone 2** [CQI P-19]: 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 1 **[**P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.	**Milestone 4** [CQI P-19]: 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 1 [P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: n/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 Milestone 4 Estimated Incentive Payment: $107,617 **Milestone 5 [1-23]** Increase specialty care clinic volumes Metric 1.[I-23.2]: increased numbers o unique patients Baseline / Goal: the number of unique patients seen by TSC fellows will increase to 500 in DY3	I **Milestone 6 [1-23]** Increase specialty care clinic volumes Metric 1.[I-23.2]: increased numbers o unique patients Baseline / Goal: the number of unique patients seen by TSC fellows will increase to 600 in DY4 Data Source: Scheduling system and EMR Milestone 6 Estimated Incentive Payment: $230,236	**Milestone 6** [I-31]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. the number of unique patients seen by TSC fellows will increase to 700 in DY5 Data Source: Scheduling system and EMR. Milestone 6 Estimated Incentive Payment: $222,453

084597603.1.8 Pass 2	***1.9.1***	***1.9.1(A-D)***	A proposal to expand a Child Psychiatry Fellowship Program
TEXAS TECH HS CTR FAMILY MED			*TPI: 084597603*
Related Category 3 Outcome Measure(s):	084597603.3.15 Pass 2 084597603.3.16 Pass 2 084597603.3.17 Pass 2	*IT-14.6* *IT-14.7* *IT-14.8*	*Percent of trainees who have spent at least 5 years in a HPSA or MUA* *Percent of trainees who report they plan to practice in HPSA or MUA* *Percent of trainees who report they plan to serve Medicaid populations.*

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: n/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 Milestone 2 Estimated Incentive Payment: $65,332 **Milestone 3 [1-23]** Increase specialty care clinic volumes Metric 1.[I-23.2]: increased numbers o unique patients Baseline / Goal: the number of unique patients seen by TSC fellows will increase from the baseline in DY1 estimated to be 300 to 400 in DY2 Data Source: Scheduling system and EMR Milestone 3 Estimated Incentive Payment: $65,332	Data Source: Scheduling system and EMR Milestone 5 Estimated Incentive Payment: $107,617		
Year 2 Estimated Milestone Bundle Amount: $195,996	Year 3 Estimated Milestone Bundle Amount: $215,234	Year 4 Estimated Milestone Bundle Amount: $230,236	Year 5 Estimated Milestone Bundle Amount: $222,453
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 863,919			

Project Option 1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

Unique Project ID: 127376505.1.1
Performing Provider Name/TPI: Emergence Health Network/127376505

Project Summary:

Provider: Emergence Health Network (EHN), formerly known as the EI Paso Mental Health & Mental Retardation (MHMR), was established as the Local Mental Health Authority pursuant to Chapter 534 of the Texas Health & Safety Code. EHN maintains 24 locations in EI Paso County and provides a comprehensive array of services, designed for both adults and children. Individuals are involved in treatment plan development, assessment and in full spectrum of mental health services such as psychiatric, case management, crisis hotline, consumer peer support psychosocial rehabilitation and therapy and substance abuse. EHN operates with a well trained team of 450 staff--providers, management, clinical and non-clinical support staff.

Intervention: The Extended Observation Unit is a diversionary service that presently does not exist in El Paso County. Care delivery gaps for mental health patients from within the context of the general public and those that are incarcerated that the proposed project will address involve the following: 1) wait times (172+ hours) at local emergency rooms to receive appropriate bio-psychosocial services; 2) limited options for appropriate community based services and a shortage in acute/sub-acute inpatient beds. As a stabilization and treatment alternative, the EOU will reduce the cost associated with unnecessary inpatient hospitalizations by way of addressing specific project and regional goals. The proposed scope of work of this new initiative will include a comprehensive assessment of behavioral health crisis, rapid stabilization methodologies, crisis resolution, aftercare continuum of services, and the reduction strategies of inpatient and law enforcement interventions. Furthermore, the scope also involves the operations of the EOU. Significant attention and detail in planning, analysis, development, reporting, policy formation relative to plans and protocols for the implementation and operations of the EOU, including the hiring of staff and evaluation of crisis services will be achieved in partnership with community stakeholders of a broad representation. To that end, the 5 year expected outcome is a reduction in the utilization of the local emergency rooms, jails and state hospitals for treatment by individuals presenting in a psychiatric crisis. The expected patient benefit is that individuals will have access to behavioral health care in the most appropriate settings.

Target population: The target population for this project is individual's with bio psychosocial needs to include substance abuse, non-medical detoxification, therapeutic interventions, medication maintenance and stabilization. Total population served = 4,380.

Category 1 or 2 expected patient benefits: With implementation of the EOU, the expected outcome is a reduction in the utilization of the local emergency rooms, jails and state hospitals for treatment. The expected patient benefit is that individuals will have access to behavioral health care in the most appropriate setting.

Category 3 outcomes: The goal is to reduce inappropriate utilization of local emergency departments.

Scope of Project: This is a new initiative.

Project Description:
Emergence Health Network ("EHN") proposes to develop an Extended Observation Unit ("EOU") as an alternative to inappropriate systems of care.

The EOU will serve as a stabilization and treatment location for individuals presenting in crisis with behavioral health needs. Community stakeholders to include law enforcement, first responders and other community providers will be educated regarding the service availability in the EOU. By design, the EOU will be able to serve individuals that are of voluntary and involuntary status, thereby avoiding the need to take these individuals to the local emergency departments or inappropriate systems of care. Individuals that present at the EOU will receive a medical screening and/or clearance. All non-emergent medical needs will be addressed through an escalated medical clearance protocol. The EOU will have the infrastructure to serve all of the individual's bio psychosocial needs to include substance abuse, non-medical detoxification, therapeutic interventions, medication maintenance and stabilization.

The current behavioral health care system in El Paso, TX has limited options for appropriate community based services and a shortage in acute/sub-acute inpatient beds. This results in individuals receiving treatment in local emergency departments, the criminal justice system and other systems of care. When individuals are treated in less desirable settings, the cost to the community significantly increases.

Goals and Relationship to Regional Goals:
Implementation of this proposed project will provide an additional choice for appropriate behavioral health crisis resolution. The EOU will alleviate the burden currently placed on local emergency departments and first responders. Secondly, the EOU will be an avenue for law enforcement to divert individuals in crisis to more appropriate settings.

Project Goals:
- Increase access to appropriate behavioral health services.
- Decrease utilization of inappropriate systems of care.
- Reduce the overall volume of individuals utilizing hospital emergency departments for psychiatric care.

This project meets the following regional goals:
- Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care.

EHN believes that early intervention and access to behavioral health services decreases the utilization of inappropriate systems of care. When services are provided in appropriate settings,

such as an EOU, the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Challenges:
The primary challenge for this project will be to engage treating physicians, law enforcement, and other community stakeholders to utilize the EOU as an appropriate community based service for individuals with behavioral health needs. EHN will overcome this challenge by providing educational meetings to community stakeholders. EHN will collaborate with community stakeholders to develop and implement processes related to the EOU.

5-Year Expected Outcome for Provider and Patients:
Emergence Health Network expects to see a reduction in the number of emergency room visits utilized by individuals presenting in a psychiatric crisis. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
The EOU is a new initiative for the community; therefore EHN estimates to serve 1,095 individuals in year 3; 1,460 in year 4; and 1,825 in year 5. Total individuals expected to be served under this project is 4,380.

Rationale:
The EOU will assist the El Paso Community by diverting individuals away from the local Emergency Departments and law enforcement contact to a more appropriate treatment setting. Utilization of the EOU will result in an overall cost savings for the community. Services provided in the EOU will include:

- Prompt and comprehensive assessment of a behavioral health crisis
- Rapid stabilization in a secure, protected, and safe environment
- Crisis resolution
- Linkage to appropriate aftercare services
- Reduction of inpatient and law enforcement interventions

"Inappropriate holding of individuals with mental health needs in local emergency rooms" *(Regional Strategic Health Framework Needs Assessment Report 2011)* was identified as an area requiring improvement. It was identified that individuals with mental health needs are in local emergency rooms for up to 172 hours awaiting appropriate services. On a monthly basis there is an average of approximately 374 individuals waiting in an emergency department for behavioral health care. Of those 374 individuals and average of 164 are admitted into an inpatient psychiatric facility. In addition, on a monthly basis there is an average of 300 individuals in the El Paso County Detention Facility identified with behavioral health needs. Implementation of this proposed project will provide an additional choice for appropriate behavioral health crisis resolution, alleviate the burden currently placed on local emergency departments and first responders and be an avenue for law enforcement to divert individuals in crisis to more appropriate settings.

Project Components:

Through the EOU, EHN proposes to meet the following project 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 (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).* EHN will host meetings with all affected and interested stakeholders to include County Commissioner's Court, El Paso Judicial System, Public Defender's Office, District Attorney's Office, El Paso Sherriff's Office, County Attorney's Office, El Paso Police Department, all local emergency departments, private and public inpatient psychiatric facilities, outpatient behavioral health providers and the El Paso Homeless Coalition. The purpose of the committees will be to discuss appropriate crisis stabilization services, analyze the current crisis continuum of care and assess the behavioral health needs of individuals currently receiving crisis services in the community. Outcomes shall include establishing Memorandum of Understandings, Business Associate Agreements, and plans and protocols for implementation of the EOU. The committee will reconvene on a regular basis to assess the impact of the implementation of the EOU on the community.

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.* EHN will conduct a mapping and gap analysis of the current continuum of care for crisis services. The written plan will include current utilization patterns, eligibility criteria for each service array.

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).* EHN will conduct a mapping and gap analysis of the current continuum of care for crisis services. The analysis will assess individuals receiving crisis services in jails, EDs, psychiatric hospitals, and other access points.

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.* On a monthly basis, EHN will monitor impact on access and quality of services through data collection. Key community stakeholders will participate in the meetings to assist in identifying "lessons learned" and implementation of interventions as challenges are identified. EHN is the designated Mental Health/IDD Authority therefore will serve as the community safety-net.

EHN has chosen not to implement the following project components:

d) *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* EHN has chosen to implement an EOU as the service model for this project.

Unique community need identification numbers the project addresses:

- CN.3 – Behavioral Health

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

Currently, an EOU does not exist in El Paso County. The initiative will improve access to appropriate community based behavioral health care.

No other federal funding is being utilized for this initiative.

Related Category 3 Outcome Measures:

OD-9 Right Care, Right Setting:

IT 9.2 ED appropriate utilization

- Reduce Emergency Department visits for target conditions
  - Behavioral Health/Substance Abuse

Reasons/rationale for selecting the outcome measures:

The expected outcome is that there will be a reduction in the utilization of emergency departments and criminal justice system as individuals will receive the needed care in the EOU. EHN selected the outcome measures to address "inappropriate holding of individuals with mental health needs in local emergency rooms" *(Regional Strategic Health Framework Needs Assessment Report 2011)*.

The Extended Observation Unit is a diversionary service which will reduce the cost associated with unnecessary inpatient hospitalizations. In a randomized trial study conducted on the short – term acute residential treatment for veterans, co-authors (Hawthorne, Green, Gilmer, Garcia, Hough, Lee, Hammond, & Lohr, 2005) stated, "In this randomized trial, START—an alternative to inpatient treatment was less costly, yielded higher levels of satisfaction with services, and produced similar outcomes to those achieved with hospital treatment. The results of this study provide support for a certified and accredited hospital alternative treatment model that is suitable for adults who need voluntary acute psychiatric care and who meet age and medical criteria. These results add to the accumulated body of research supporting non–hospital-based acute psychiatric alternatives". In this study, the mean cost for the START participants showed a 65% decrease in cost as opposed to the individuals who were treated in an inpatient hospital setting.

Relationship to other Projects: The EOU project is related to the Crisis Respite Unit (Project #2.1), Crisis Stabilization for IDD population (Project #2.2) and Expand Behavioral Health Providers (Project #1.2). The proposed projects offer additional crisis stabilization alternatives

for the community. The Expand Behavioral Health Providers project will ensure access to appropriate care in community settings.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: No other providers in the RHP are establishing an EOU. EHN will participate in scheduled meetings with other providers in the RHP to promote collaborative learning around shared, similar projects, or other projects impacting the community.

Project Valuation: Valuation of the EOU was based on average cost and length of stay related to individuals that require inpatient hospitalization, individuals served by local emergency departments, and individuals incarcerated.

127376505 1.1	*1.13.1*	*1.13.1.A.B.C.E*	*EXTENDED OBSERVATION UNIT*	
Emergence Health Network				***127376505***
Related Category 3 Outcome Measure(s):		*127376505 3.1*	OD-9 Right Care, Right Setting 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 services providers. Metric 1 (P-1.1): Number of meetings and participants. Baseline/Goal: Engage and educate community stakeholders on psychiatric emergency services Data Source: Attendance lists Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,214,321 **Milestone 2** (P-2) Conduct mapping and gap analysis of current crisis system. Metric 1 (P-2.1): Produce a written analysis of community needs for crisis services. Baseline/Goal: Identify community needs for crisis services. Data Source: Written plan	**Milestone 5** (P-6) Evaluate and continuously improve crisis services. Metric 1 (P-6.1): Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Goal: Evaluate and improve crisis services. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 5: Estimated Incentive Payment (maximum amount): $2,068,181 **Milestone 6** (I-12): Utilization of appropriate crisis alternatives Metric 1 (I-12.1):% increase in utilization of appropriate crisis alternatives. Goal: EHN expects to serve 1,095 individuals (24% increase in utilization of appropriate crisis alternatives)		**Milestone 7** (I-12): Utilization of appropriate crisis alternatives Metric 1 (I-12.1):% increase in utilization of appropriate crisis alternatives. Goal: EHN expects to serve 1,460 individuals (33% increase from DY2 in utilization of appropriate crisis alternatives) Data Source: Claims, encounter, and clinical record data. Milestone 7 Estimated Incentive Payment: $5,001,708	**Milestone 8** (I-12): Utilization of appropriate crisis alternatives Metric 1 (I-12.1):% increase in utilization of appropriate crisis alternatives. Goal: EHN expects to serve 1,825 individuals (66% increase from DY2 in utilization of appropriate crisis alternatives) Data Source: Claims, encounter, and clinical record data. Milestone 8 Estimated Incentive Payment: $5,805,462

127376505 1.1	*1.13.1*	*1.13.1.A.B.C.E*	*EXTENDED OBSERVATION UNIT*	
Emergence Health Network				***127376505***
Related Category 3 Outcome Measure(s):		*127376505 3.1*	OD-9 Right Care, Right Setting 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 2: Estimated Incentive Payment *(maximum amount):* $1,214,321 **Milestone 3** (P-4) Hire and train staff to implement identified crisis stabilization services. Metric 1 (P-4.1): Number of staff hired and trained. Baseline/Goal: Hire and train staff. Data Source: Training curricula Milestone 3: Estimated Incentive Payment (maximum amount): $1,214,321 **Milestone 4** (P-5) Develop administration of operational protocols and clinical guidelines for crisis services. Metric 4 (P-5.1): Completion of policies and procedures. Baseline/Goal: Complete operational protocols and clinical guidelines. Data Source: Internal policy and procedures documents and operations manual.	Data Source: Claims, encounter, and clinical record data. Milestone 6 Estimated Incentive Payment: $2,068,181			

127376505 1.1	***1.13.1***	***1.13.1.A.B.C.E***	***EXTENDED OBSERVATION UNIT***
Emergence Health Network			***127376505***
Related Category 3 Outcome Measure(s):		*127376505 3.1*	OD-9 Right Care, Right Setting 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 4: Estimated Incentive Payment (maximum amount): $1,214,321			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,857,284	Year 3 Estimated Milestone Bundle Amount: $4,136,362	Year 4 Estimated Milestone Bundle Amount: $5,001,708	Year 5 Estimated Milestone Bundle Amount: $5,805,462
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $19,800,816			

95769

Project Option 1.14.1 - Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county. Examples of strategies could include marketing campaigns to attract providers, enhanced residency programs or structured financial and non-financial incentive programs to attract and retain providers, identifying and engaging individual health care workers early in their studies/careers and providing training in identification and management of behavioral health conditions to other non-behavioral health disciplines (e.g., ANPs, PAs).

Unique Project ID: 127376505.1.2
Performing Provider Name/TPI: Emergence Health Network/127376505

Project Summary

Provider: Emergence Health Network (EHN), formerly known as the EI Paso Mental Health & Mental Retardation (MHMR), was established as the Local Mental Health Authority pursuant to Chapter 534 of the Texas Health & Safety Code. EHN maintains 24 locations in EI Paso County and provides a comprehensive array of services, designed for both adults and children. Individuals are involved in treatment plan development, assessment and in full spectrum of mental health services such as psychiatric, case management, crisis hotline, consumer peer support psychosocial rehabilitation and therapy and substance abuse. EHN operates with a well-trained team of 450 staff--providers, management, clinical and non-clinical support staff.

Intervention: This new EHN initiative will develop and expand the community's capacity to overcome recruitment challenges of behavioral health providers to the region. As a quality of life factor, the proposed project will decrease recidivism which is attributed to the over utilization of inappropriate systems of care (e.g. emergency rooms). Conversely, increase access to care and choice in providers by individuals with behavioral health needs are project outputs that will result in favorable outcomes such as better care delivery, better patient health, and cost-savings realized for all stakeholders. The proposed scope of work of this new initiative will include a comprehensive assessment (i.e. gap analysis) of behavioral health specialty vocations in the region, recruitment and training implementation plan of behavioral health providers, and an impact evaluation on access to care, quality of service delivery, patient health outcomes, and cost savings. To that end, the 5 year expected outcome is to document customer satisfaction and a reduction in the utilization of the local emergency rooms. The expected patient benefit is that individuals will have greater access to behavioral health care in the most appropriate settings.

Target population: The target population for this project is individuals with behavioral health needs, as this project will increase access to services for those individuals. Total population served = 1,000.

Category 1 or 2 expected patient benefits: Implementation of this project will increase access to appropriate behavioral health services as well as decrease utilization of inappropriate systems of care.

Category 3 outcomes: EHN believes that this project will increase customer satisfaction due to enhanced access to behavioral health including choice in providers.

Scope of Project: This is a new initiative.

Project Description:

Emergence Health Network ("EHN") is proposing to expand the capacity and access to behavioral health care by increasing the number of behavioral health providers in the community.

The intention of this project is to increase the number of psychiatrists and licensed behavioral health providers in order to expand capacity and access in the El Paso community. The project was initiated in response to limited number of behavioral health providers in the county. Currently El Paso County has 0.1 psychiatrists per 100,000 people. Additionally, there are 4.8 licensed psychologists per 100,000 people, compared to 14.9 per 100,000 statewide (The Greater El Paso Chamber of Commerce, "The Crisis in El Paso").

EHN will collaborate with community stakeholders and form a committee to conduct a gap analysis and identify strategies for recruitment. Committee will regularly assess interventions and identify opportunities for improvement.

Goals and Relationship to Regional Goals:
The goal of this project is to expand capacity and access to behavioral health care by increasing the number of behavioral health providers in the community. El Paso, TX is considered a Health Provider Shortage Area (HPSA) and EHN believes that expanding and enhancing the capacity of behavioral health care services will reduce recidivism and expand access to appropriate levels of care.

Project Goals:
- Increase access to appropriate behavioral health services.
- Decrease utilization of inappropriate systems of care.

This project meets the following regional goals:
- Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care.

EHN believes that early intervention and access to behavioral health services decreases the utilization of inappropriate systems of care. When services are provided in appropriate settings the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Challenges:
Community attractiveness, local economy, climate, demographics of the population, social and lifestyle preferences, and competitive salary are all major challenges which influence location/recruitment decisions.

5-year Expected Outcome for Provider and Patients:
EHN expects to see improvements in quality of life and customer satisfaction through implementation of this project. In addition, expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
EHN currently employees 2 psychiatrists, 3.25 direct-care licensed clinicians, and zero advanced nurse practitioners.

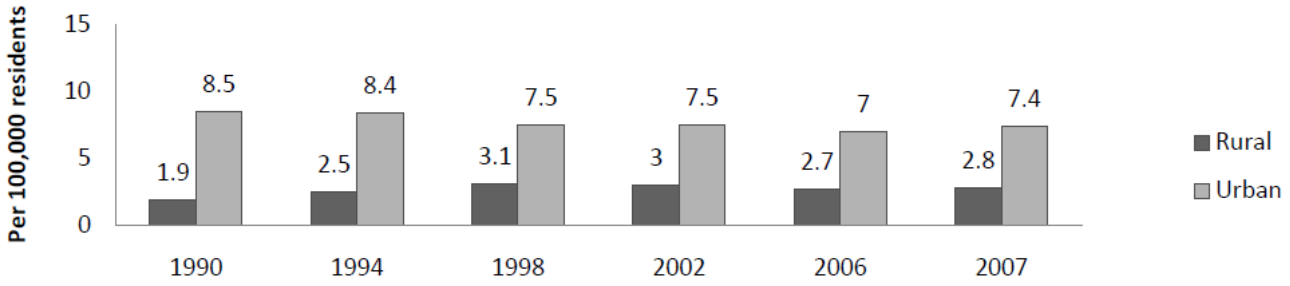
Rationale:

According to a survey conducted by Merritt Hawkins, "More than half of all psychiatrists are 55 years old or older and are nearing retirement age, while fewer medical school graduates are showing an

interest in psychiatry. As the supply of psychiatrists decreases, population growth, population aging, economic challenges, and two wars are driving demand for mental health services higher. The U.S. Department of Health and Human Services (HHS) projects that demand for psychiatric services will increase by 19 percent from 1995 to 2020. HHS already designates 3,132 Health Professional Shortage Areas (HPSAs) nationwide for mental health, in which 80 million Americans live. (Survey: Demand for Psychiatrists Peaking, 2010)

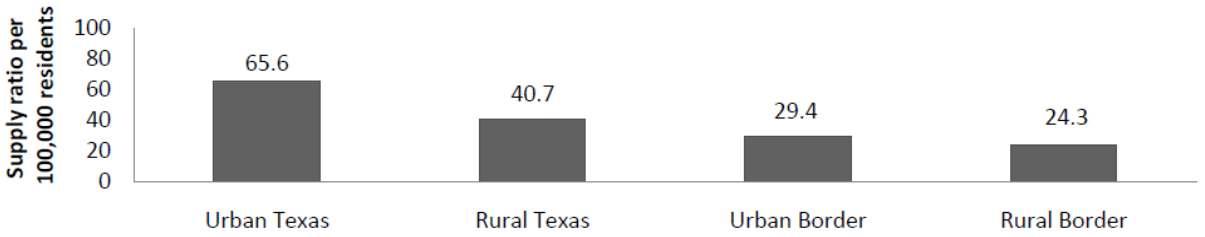
The supply of mental health providers is poorly distributed across Texas but is least available in rural and border counties such as El Paso. The figure below shows the discrepancy in urban and rural distributions of psychiatrists.

Figure 4. Psychiatrists in Urban and Rural Texas Counties (1990–2007)



This disparity is even more apparent along the Texas border. For example, the supply rate of licensed professional counselors (LPCs) in Texas per 100,000 residents is 65.5 in urban regions and 40.7 in rural regions, but drops to only 29.4 in urban areas of the border region and is much lower in rural areas of the border. (www.hogg.utexas.edu; Health Care in Texas: Critical Workforce Shortages in Mental Health)

Figure 5. Border Region: Licensed Professional Counselors Supply Ratio (2007)



Project Components:

Through this project, EHN proposes to meet all requirements of the following project components:

a) *Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and the issues contributing to the gaps.* EHN will conduct a gap analysis to identify needed behavioral health specialties lacking in El Paso County.
b) *Develop plan to remediate gaps identified and data reporting mechanism to assess progress toward goal. This plan will specifically identify:*

- *The severity of shortages of behavioral health specialists in a region by type (psychiatrists, licensed psychologists, nurse practitioners, physicians assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, peer support specialists, community health workers etc.)*
- *Recruitment targets by specialty over a specified time period.*
- *Strategies for recruiting healthcare specialists*
- *Strategies for developing training for primary care providers to enhance their understanding of and competency in the delivery of behavioral health services and thereby expand their scope of practice.* Based on gap analysis EHN will develop a recruitment plan that will address recruiting strategies and training.

c) *Assess and refine strategies implemented using quantitative and qualitative data. Review the intervention(s) impact on behavioral health workforce in HPSA areas 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.* On a monthly basis, EHN will monitor impact on access and quality of services through data collection. Key community stakeholders will participate in the meetings to assist in identifying "lessons learned" and implementation of interventions as challenges are identified. EHN is the designated Mental Health/IDD Authority therefore will serve as the community safety-net.

Unique community need identification numbers the project addresses:

- CN.3 – Behavioral Health

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

Implementation of this project will significantly enhance existing services by improving quality of life and customer satisfaction.
No other federal funding is being utilized for this initiative.

<u>Related Category 3 Outcome Measure(s):</u>
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction
(1) Are getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measures:

The goal of expanding behavioral health providers is to remove barriers and increase access to behavioral health services in the community. Additionally, the project will enhance EHN's current provider base in order to increase patient choice with culturally and linguistically diverse providers, thus having a positive effect on customer satisfaction.

<u>Relationship to other Projects:</u> Implementation of this project is not related to other proposed projects.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
No other providers in the RHP are implementing projects related to expansion of behavioral health providers however there are several projects related to expansion of specialty care. EHN will

participate in scheduled meetings with other providers in the RHP to promote collaborative learning around shared, similar projects, or other projects impacting the community.

Project Valuation: EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals with a behavioral health diagnosis. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments, law enforcement, and other systems of care. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

127376505 1.2	*1.14.1*	*1.14.1.A.B.C.*	*EXPAND BEHAVIORAL HEALTH PROVIDERS*
Emergence Health Network			***127376505***
Related Category 3 Outcome Measure(s):	*IT-6.1*	*127376505 3.2*	OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information.

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 gap analysis. Metric 1 (P-1.1): Baseline analysis of behavioral health patient population, which may include elements such as consumer demographics, proximity to sources of specialty care, utilization of Emergency Department , other crisis and inpatient services including state hospital services used by residents of the region, incarceration rates, most common sites of mental health care, most prevalent diagnoses, co-morbidities; existing provider caseload, provider demographics and other factors of regional significance Baseline/Goal: Establish a baseline Data Source: HPSA data; Provider licensing and enrollment data from state and local sources; Claims and encounters from regional and state data sources; Provider and consumer survey, interview and focus group data Milestone 1 Estimated Incentive Payment *(maximum amount):* $212,444 **Milestone 2** (P-2) Remediation Plan Metric 1 (P-2.1): Remediation plan	**Milestone 3** (P-4) Evaluate and continuously improve strategies. Metric 1 (P-4.1): Project planning and implementation documentation describes plan, do, study, act quality improvement cycles. Goal: Identify and improve strategies. Data Source: Project reports Milestone 3: Estimated Incentive Payment *(maximum amount):* $256,058 **Milestone 4** (I-10): Emergency Department use Metric 1 (I-10.1): % reduction in inappropriate use of Emergency Department care by individuals with mental illness or substance-use disorders. Goal: 6.5% reduction (200 individuals) Data Source: Claims data and encounter data from ED and project service data. Milestone 4 Estimated Incentive Payment: $256,058	**Milestone 6** (I-10): Emergency Department use Metric 1 (I-10.1): % reduction in inappropriate use of Emergency Department care by individuals with mental illness or substance-use disorders. Goal: 9.7% reduction (300 individuals) Data Source: Claims data and encounter data from ED and project service data. Milestone 6 Estimated Incentive Payment: $395,610 **Milestone 7** (I-12): Cultural and Linguistic Diversity Metric 1 (I-12.1): % increase in number of culturally and linguistically diverse behavioral health providers, especially in HPSA's along the Texas/Mexico border. Goal: 11% increase, over baseline, in number of culturally and linguistically diverse behavioral health providers, especially in HPSA's along the Texas/Mexico border. Data Source: Project data, Provider	**Milestone 8** (I-10): Emergency Department use Metric 1 (I-10.1): % reduction in inappropriate use of Emergency Department care by individuals with mental illness or substance-use disorders. Goal: 16% reduction (500 individuals) Data Source: Claims data and encounter data from ED and project service data. Milestone 8 Estimated Incentive Payment: $407,478 **Milestone 9** (I-12): Cultural and Linguistic Diversity Metric 1 (I-12.1): % increase in number of culturally and linguistically diverse behavioral health providers, especially in HPSA's along the Texas/Mexico border. Goal: 15% increase, over baseline, in number of culturally and linguistically diverse behavioral health providers, especially in HPSA's along the Texas/Mexico border. Data Source: Project data, Provider

127376505 1.2	***1.14.1***	***1.14.1.A.B.C.***	***EXPAND BEHAVIORAL HEALTH PROVIDERS***	
Emergence Health Network				***127376505***
Related Category 3 Outcome Measure(s):	*IT-6.1*	*127376505 3.2*	OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information.	
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)**
which addresses elements relating to shortages identified in the gap analysis. Goal: Address elements relating to identified shortages. Data Source: Written plan from Regional Partnerships. Milestone 2: Estimated Incentive Payment *(maximum amount):* $212,444	**Milestone 5** (I-12): Cultural and Linguistic Diversity Metric 1 (I-12.1): % increase in number of culturally and linguistically diverse behavioral health providers, especially in HPSA's along the Texas/Mexico border. Goal: 7% increase, over baseline, in number of culturally and linguistically diverse behavioral health providers, especially in HPSA's along the Texas/Mexico border. Data Source: Project data, Provider registration, survey data. Milestone 5 Estimated Incentive Payment: $256,058		registration, survey data. Milestone 7 Estimated Incentive Payment: $395,610	registration, survey data. Milestone 9 Estimated Incentive Payment: $407,478
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $424,888	Year 3 Estimated Milestone Bundle Amount: $768,174		Year 4 Estimated Milestone Bundle Amount: $791,220	Year 5 Estimated Milestone Bundle Amount: $814,956
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,799,238				

95798

Project Option 1.13.2 - "Other" project option: Implement other evidence-based project to develop behavioral health stabilization services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Unique Project ID: 127376505 1.3 **Performing Provider Name/TPI:** Emergence Health Network/127376505

Project Summary:

Provider: Emergence Health Network (EHN), formerly known as the El Paso Mental Health & Mental Retardation (MHMR), was established as the Local Authority for individuals with Intellectual and Developmental Disabilities (IDD). EHN provides a comprehensive array of services, designed for individuals with IDD that include screening, eligibility, service coordination, and community services. EHN operates with a well-trained team of 450 staff--providers, management, clinical and non-clinical support staff.

Intervention: The Crisis Stabilization Unit is an alternative to the cyclic pattern of long term support and acute crisis intervention for individuals with IDD) and SPMI. The proposed scope of work of this new initiative will include planning, coordination, and development and implementation activities with community stakeholders regarding an evidenced-based long-term crisis intervention and stabilization services model for the region. As a stabilization and treatment alternative, the project will utilize specialized mental health teams to coordinate community treatment interventions for the target population albeit a service delivery model known as START: Systematic, Therapeutic, Assessment, Respite, and Treatment. The model will encompass both inter-disciplinary collaboration and wraparound evidence-based practices to assist with minimizing inappropriate utilization of higher levels of care, inappropriate levels of care and systems developed for primarily medical needs versus mental health needs. To that end, the 5 year expected outcome is to document quality of life and functional status improvements for individuals receiving services in this program.

Target population: The target population for this project is individuals with IDD and SPMI. This project will affect at least 163 individuals.

Category 1 or 2 expected patient benefits: With the implementation of a crisis stabilization team, EHN expects to increase the utilization of appropriate crisis alternatives. The patient will also benefit from receiving behavioral healthcare in the most appropriate setting.

Category 3 outcomes: The goal is to improve the quality of life and improve mental health outcome measures.

Scope of Project: This is a new initiative.

Project Description:

Emergence Health Network ("EHN") is proposing to develop a crisis stabilization unit for individuals with intellectual and developmental disabilities ("IDD") and/or co-occurring serious and persistent mental illness (SPMI).

The intention of this project is to provide a resolution to the cyclic pattern of long term support and acute crisis intervention for individuals with IDD and SPMI. The project was initiated in response to the consensus that specialized MH teams were necessary to coordinate community treatment interventions for persons with IDD and SPMI. This population often has complex medical issues, high emergency department use, and far lengthier stays in state psychiatric hospitals than the general population of mental health service users.

EHN will collaborate with community stakeholders to explore the development of an evidenced-based long-term crisis intervention and stabilization services model, START: Systematic, Therapeutic, Assessment, Respite, and Treatment. START Services is a program of the Institute on Disability/UCED, University of New Hampshire. START is an initiative that strengthens efficiencies and service outcomes for individuals with IDD and SPMI through consultation, training, and technical assistance on crisis stabilization services. The START model emphasizes the use of: a multi-modal approach; an interdisciplinary team; trained personnel; family support and education; service linkages and cross systems accountability; crisis supports; and ongoing evaluation of service outcomes. START Coordinators provide outreach, assessment, consultation; 24 hour crisis needed support, and follow-up. START clinical teams include a number of professionals including psychiatrists, social workers, therapists and behavioral specialists. The model will encompass both inter-disciplinary collaboration and wraparound evidence-based practices to assist with minimizing inappropriate utilization of higher levels of care, inappropriate levels of care and systems developed for primarily medical needs versus mental health needs (www.centerforstartservices.com).

Goals and Relationship to Regional Goals:
EHN believes that early intervention and access to behavioral health services decreases the utilization of inappropriate systems of care. When services are provided in appropriate settings the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Project Goals:

- Increase access to appropriate behavioral health services.
- Decrease utilization of inappropriate systems of care.
- Utilize an interdisciplinary team to address crisis situations and circumstances.
- Increase community involvement.
- Raise crisis expertise in our community.
- Increase rates of satisfaction by families and care recipients.

This project meets the following regional goals:

- Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care.

EHN believes that early intervention and access to behavioral health services decreases the utilization of inappropriate systems of care. When services are provided in appropriate settings the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Challenges:

EHN has identified engagement of family members and service providers as a challenge for this project. This model of service delivery is intensive and utilizes an interdisciplinary team. Roles and responsibilities will need to be clarified within the service system for members of that interdisciplinary team in order to facilitate engagement.

5-Year Expected Outcome for Provider and Patients:
EHN expects to see improvements in quality of life/functional status outcomes for individuals receiving services in this program. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
The crisis stabilization for IDD population is a new initiative for the community; therefore EHN estimates to serve 75 individuals in year 4 and 88 in year 5. Total individuals expected to be served under this project is 163.

Rationale:
In 1999, the US Department of Health and Human Services Report to the Surgeon General of the United States on Mental Health described the system of mental health care as "multifaceted and complex" made up of public and private providers, multiple agencies and disciplines. The report attributed the configuration of the system to advances in mental health practices, reform movements, financial incentives and variable payment streams. However, the report also acknowledged that the "hybrid" system does not always "function in a coordinated manner", creating problems especially for people with complex needs and limited means. Currently there are approximately 1156 individuals with IDD receiving services. It is EHN's belief that many crises are underreported due to the complex needs these individuals have. Current crisis services do not address their unique needs.

The evidence indicates that the inability of mental health providers to coordinate their efforts with other providers and agencies has adversely affected services to individuals with MI/IDD (www.centerforstartservices.com). EHN means to utilize the community networks available within the El Paso County area in efforts to increase minimally to non-involved community members and providers awareness and in efforts to substantially increase the crisis expertise throughout individuals and providers alike. Initial corralling of resources would include (not limited to): The Center for START Services; IDD Providers and MH Providers within the El Paso County area; the Local Mental Health Authority; individual and private Providers; multi-disciplinary teams to include: psychiatric medical professionals, nurses, counselors, medical and physical health providers, and family member/care takers.

START provides a number of opportunities for consultation, education, and individualized treatment planning. As described earlier, all services emphasize an interdisciplinary team

approach to care. START collaborates with a number of community inpatient providers of mental health care. Team members receive START Coordinator certification. Additionally, as part of the intensive certification process, START Coordinators are to provide stabilization skills and techniques to community stakeholders.

No other federal funding is being utilized for this initiative.

Project Components:

Through the IDD Crisis Stabilization Unit, EHN proposes to meet the following project components:

a) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* On a monthly basis, EHN will monitor impact on access and quality of services through data collection. Key community stakeholders will participate in the meetings to assist in identifying "lessons learned" and implementation of interventions as challenges are identified. EHN is the designated Mental Health/IDD Authority therefore will serve as the community safety-net.

Unique community need identification numbers the project address:

- CN.3-Behavioral Health

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

Currently, there is not a crisis stabilization unit for individuals with developmental disabilities in El Paso County. This will enhance the current delivery system by implementing an intensive wraparound process designed to improve symptoms and functioning in individuals with IDD and SPMI.

No other federal funding is being utilized for this initiative.

<u>Related Category 3 Outcome Measure(s):</u>

OD-10 Quality of Life/Functional Status
IT- 10.1 Quality of Life

Reasons/rationale for selecting the outcome measures:

EHN chose OD-10/IT-10.1 as an outcome measure to demonstrate improvement in symptoms and functioning. START outcomes have shown increased benefits to clients overtime including improvement in the Aberrant Behavior Checklist (validated functioning assessment tool) scores

and Family Experiences Interview Schedule (FEIS) developed by Tessler and Gamache (1995) which measures significant aspects of mental health service effectiveness from a family member perspective. START clients tend to stay out of the hospital and not seek emergency healthcare services when they are in the program. Quality of life is evidenced by the START Program's national statistic which includes its current retention rate for home placements of 95%, two-day reduction in average length of stay per hospitalization, and improvement in mental health outcome measures and comparisons.

Relationship to other Projects: The crisis stabilization for IDD population project is related to the Extended Observation Unit (Project #1.1) and Crisis Respite Unit (Project #2.1). The proposed projects offer additional crisis stabilization alternatives on the crisis continuum of care.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: No other providers in the RHP are establishing a crisis stabilization unit for individuals with IDD and SPMI. EHN will participate in scheduled meetings with other providers in the RHP to promote collaborative learning around shared, similar projects, or other projects impacting the community.

Project Valuation: EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals diagnosed with an intellectual/developmental disability. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments and other systems of care. It has been demonstrated that the utilization of an IDD crisis stabilization units is cost effective and is a best practice in addressing the needs of individuals presenting in crisis. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

1273765051.3	***1.13.2***	***1.13.2***	***CRISIS STABILIZATION FOR IDD POPULATION***	
Emergence Health Network				***127376505***
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127376505 3.3*	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-2) Conduct mapping and gap analysis of current crisis system Metric 1 (P-2.1): Produce a written analysis of community needs for crisis services Baseline/Goal: Establish a baseline of quarterly admissions Data Source: Written Plan Milestone 1 Estimated Incentive Payment *(maximum amount): $320,620* **Milestone 2** (P-3) Develop implementation plans for needed crisis services. Metric 1 (P-3.1): Produce data driven written action plans for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs	**Milestone 3** (P-4) Hire and train staff to implement identified crisis stabilization services Metric 1 (P-4.1): Number of staff hired and trained Goal: Hire and train staff Data Source: Training curricula Milestone 3: Estimated Incentive Payment *(maximum amount): $484,631* **Milestone 4** (P-5): Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 (P-5.1): Completion of policies and procedures Goal: Complete policies and procedures		**Milestone 5** (I-12): Utilization of appropriate crisis alternatives Metric 1 (I-12.1): % increase in utilization of appropriate crisis alternatives Goal: 75 individuals served Data Source: Claims Encounter and Clinical Record Data Milestone 5 Estimated Incentive Payment: $958,622	**Milestone 7** (I-12): Utilization of appropriate crisis alternatives Metric 1 (I-12.1): % increase in utilization of appropriate crisis alternatives Goal: 88 individuals served. 15% increase in individuals served from DY 4. Data Source: Claims Encounter and Clinical Record Data Milestone 7 Estimated Incentive Payment: $1,012,630

1273765051.3	***1.13.2***	***1.13.2***	***CRISIS STABILIZATION FOR IDD POPULATION***	
Emergence Health Network				***127376505***
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127376505 3.3*	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)**
Goal: Develop action for specialized intervention Data Source: Written Plan Milestone 2: Estimated Incentive Payment *(maximum amount): $320,621*	Data Source: Internal policy and procedure documents and operations manual Milestone 4 Estimated Incentive Payment: $484,631			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $641,241	Year 3 Estimated Milestone Bundle Amount: $969,262		Year 4 Estimated Milestone Bundle Amount: $958,622	Year 5 Estimated Milestone Bundle Amount: $1,012,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,581,755				

City of El Paso Department of Public Health
DSRIP Project: Border Public Health Interest Group

Identifying Project and Provider Information:

Title of Project: Border Public Health Interest Group
RHP Project Identification #: 065086301.1.1
Project Option: 1.5.2 Implement intervention that involves collaborating/partnering/instituting data sharing agreements with Medicaid agencies, public health departments, academic research centers, other agencies, etc. to better assess patient populations and aid the evaluation of health disparities.
Performing Provider Name: City of El Paso Department of Public Health/065086301

Summary Information:

Provider Description:

The Performing Provider for this project is the City of El Paso Department of Public Health. The Department of Public Health has 270 employees and an annual budget of $19M. The department provides food protection, epidemiology, preparedness, laboratory, population-based health planning, WIC, and 211 Call Center services. In addition, the department is a clinical provider for dental health, immunizations, tuberculosis control, and STD diagnosis and treatment.

Primary catchment area for the public health department is the City of El Paso. The health department provides services for other municipalities within El Paso County and the unincorporated area through interlocal agreements. Finally, there are select grant programs, e.g., WIC, where the terms of the grant require the department to serve Hudspeth County. Total population for the service region is approximately 820,000.

Intervention:

The City of El Paso Department of Public Health proposes a three academic institution (Texas Tech, UT El Paso, and UT Houston School of Public Health) collaborative research interest group which will collect and analyze REAL data to describe regional/local health problems and prescribe appropriate policy/program interventions.

Description of Need:

The current demographic mix of El Paso is predictive for the nation (predominantly Hispanic with diverse socioeconomic status). As such, population-based research on prevalence and incidence of communicable and chronic diseases is especially relevant to healthcare providers and policy makers. However, there has been no neutral venue for exchange of information; strategizing on research direction; broadening the stakeholders beyond academia. As a neutral convener, the health department can facilitate sharing of information among participating

institutions; help the institutions identify and articulate common interests; and broker resolution of problems attendant to inter-academic institution collaboration.

Target Population:

The Border Public Health Interest Group (BPHIG) is a population-based initiative which will study health issues relevant to the border. Target population will be the residents of the El Paso and Hudspeth Counties, inclusive of Medicaid, undersinsured, and uninsured populations.

Benefit to Medicaid/Indigent Patients:

BPHIG will be conducting collaborative research on health problems of the region including an assessment of access to health resources for vulnerable populations. BPHIG will sensitize the community to health disparities attendant to insurance status and will advocate policy/program changes to improve access to healthcare and support service providers for low income residents.

Expected Benefit of Project:

Category 1 Milestones: Inventory existing REAL data collection systems used by healthcare institutions, agencies, private providers; standardize data definitions across collection points; develop procedures/protocols for REAL data retrieval and analysis for population-based research.

Category 3 Outcome Measures: Conduct collaborative research project on health issue for border populations; assess disproportionate effect of condition on vulnerable populations; develop/advocate recommendations for systemic improvements; demonstrate improvement in access/health status for Medicaid/uninsured populations by evaluating relationship between increased use of clinical preventive services for Medicaid/self-pay and corresponding reduction in preventable hospital admissions

Project Description:

Currently, the three academic institutions in the El Paso area (University of Texas El Paso, University of Texas Houston School of Public Health, and Texas Tech University) are engaged in population-based research activity. This regional research involves the collection and analysis of valid and reliable race, ethnicity, and language data with the intent to reduce disparities. However, there is no venue for exchange of information; strategizing on research direction; broadening the stakeholders beyond academia. The health department is proposing to establish a Border Public Health Interest Group comprised of researchers from the three major El Paso area academic institutions supplemented by epidemiology support from the health department. Representatives from all three institutions have agreed to participate in the public health interest group. Once the group is fully operational, planners envision extending the invitation to New Mexico State University and academic institutions in Juarez, Mexico to form a truly regional public health research body.

Purpose of the group will be to conduct collaborative research on pressing border health concerns, e.g., diabetes, select communicable/chronic diseases. As a neutral convener, the health

department can facilitate sharing of information among participating institutions; help the institutions identify and articulate common interests; and broker resolution of problems attendant to inter-academic institution collaboration.

Once operational, the Border Public Health Interest Group (BPHIG) will inventory research projects currently underway at three affiliated academic institutions, e.g., study of relationship of insurance status to accessing preventive health/early detection services for breast and cervical cancer for low income Hispanic women along the border. Status/findings will be shared with the group to identify synergies and opportunities for collaborative research. The group will then strategize on continuation of current or development of new research initiatives; inclusion of additional stakeholders; and identifying/accessing private and/or public funding for current/new investigations.

In addition to facilitating interaction among the three academic institutions, the health department, as a local governmental entity, can foster development of appropriate public policy to assure that research findings are translated into programs/action. Policy influence will occur through strategic dissemination of research findings and engagement of academic and non-academic partners in advocacy with public, private, and non-profit sectors.

Finally, the Border Public Health Interest Group's interaction and collaborative research activities will help educate academic institutions, hospitals, private providers, public officials, and the broader community along the border of the value of collecting/analyzing/using REAL data for informed decision-making.

Goals and Relationship to Regional Goals:

The goal of this project is to express to the broader El Paso region the synergistic value of collaborative research on health topics relevant to border populations. The relationship building attendant to full participation in BPHIG will result in the application of skills, expertise and passion of area researchers (irrespective of institutional affiliation) on health problems of common interest/concern. This sharing of REAL data collection, analysis, interpretation, and findings will improve local capacity for understanding border health problems/conditions and will help sensitize the community to the need/means for action.

Project Goals:

- Form a Border Public Health Interest Group with researcher/policy maker representation from City of El Paso Department of Public Health, University of Texas El Paso, University of Texas Houston School of Public Health, and Texas Tech University Paul Foster School of Medicine.
- Inventory current research activity to identify synergies of interest; identify research gaps
- Develop/fund/conduct pilot collaborative research project
- Apply findings from pilot project to policy/program initiatives
- Expand participation on BPHIG to other regional academic institutions
- Expand participation on BPHIG to non-research related businesses, non-profits, local governments
- Reposition BPHIG as the El Paso area "think tank' for REAL data analysis; health policy

development; and program/service intervention advocacy

This project meets the following regional goals:

The BPHIG project will enhance regional capacity to understand the macro and micro differences of border health issues. Further, the project will help prescribe culturally-driven, evidence-based interventions. The BPHIG initiative relates to the following regional goal:

- Overcome language, socio-economic, and monetary barriers to accessing healthcare resources in the region

Challenges:

The major challenge for BPHIG will be to extend the collaborative sentiment of the participating researchers to upper level administration of the respective academic institutions, i.e., getting full buy-in from the administrative hierarchy of each university. Fortunately, most funding sources now expect (demand) evidence of community collaboration, including inter-institutional for local academia. This fundamental shift in research funding philosophy from competitive to collaborative will help address the issue.

5 Year Expected Outcome for Provider and Patients:

Over a 5 year work period BPHIG will inspire a regional commitment to health improvement and demonstrate enhanced access to culturally-responsive health services. There will be a corresponding increase in "right-sourcing" of health care services. Target populations will demonstrate increased use of outpatient/preventive services and a decrease in preventable hospital admissions. A regional expectation for improved health will follow:

- better awareness of border health issues and appropriate policy/service interventions;
- greater sensitivity to the full range of causal factors of disparities;
- change in belief structure about capacity to make a difference

Improved knowledge, alone, does not yield change. Communities must be dissatisfied with current conditions and feel the capacity/power to improve circumstances. The work of BPHIG will facilitate that transition in thought, heart, and practice for residents of the El Paso region.

Starting Point Baseline:

This is a new initiative of the City of El Paso Department of Public Health; hence, baseline is zero (0).

Rationale:

The current demographic mix of El Paso is predictive for the nation (predominantly Hispanic with diverse socioeconomic status). As such, population-based research on prevalence and incidence of communicable and chronic diseases is especially relevant to healthcare providers

and policy makers. Population-based research in the El Paso community will help describe/refine who's at risk for select diseases by race, ethnicity, language, physiologic, behavioral, socioeconomic factors. Further, specific interventions (health and other) can be studied to identify best practices for health protection and disease prevention/management/control in a predominantly Hispanic population**.**

Publicly funded research projects now require evidence of collaboration. Historically, the three academic institutions in the area pursued research tracts in isolation. The expectation for collaboration is a paradigm shift. However, this shift can be facilitated by the health department as a neutral convener. The key to successful collaborative research is trust among the institutions/researchers that the responsibilities/benefits of process and outcome will be equitably shared. That trust will need to earned, incrementally, over time and experience. It is critical that the initial group research project be strategically identified/designed to mitigate risk and afford all participating institutions opportunity for added value.

Population-based research in the El Paso community will help describe/refine who's at risk for select diseases by race, ethnicity, language, physiologic, behavioral, socioeconomic and other factors AND who may be protected by one or more of the above factors. Further, specific interventions (health and other) can be studied to identify best practices for disease prevention/management/control in a predominantly Hispanic population. Work of the Border Public Health Interest Group will inform/influence health planners, clinicians, and policy makers and, therefore, is translational to all DSRIP categories.

Project Components:

There are no specific project components to Project Option 1.5.2; however, the project option does require quality improvement activities including "lessons learned," and identifying opportunities for scaling and replication of successful interventions. BPHIG will conduct an ongoing quality improvement process to address the requirements of this section.

Unique community need identification number(s) the project addresses:

CN.4 Obesity Prevention/Health Promotion
CN.6 Other Community Need as Identified by the Performing Provider

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

There is currently no coordinated approach to REAL data research; analysis/interpretation of findings; and translating research results into a policy and programs. BPHIG will demonstrate that academic institutions, public and private providers can collaborate on investigating border health issues and preparing/advocating effective interventions.

Related Category 3 Outcome Measure(s):

Outcome Domain (OD-11): Addressing Health Disparities in Minority Populations

Improvement Targets IT 11.3 Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity: Increase number of Minorities who obtain annual flu vaccine, Tdap booster, and lipid screening

Reasons/Rationale for selecting the outcome measures:

The outcome of the proposed DSRIP project for a Border Public Health Interest Group will be improved collaboration among academic researchers from the three local universities; improved standardization of data collection per REAL methodology; improved translational results/findings due to consistency in collection methodology; and improved application of research findings to program/service intervention design; and, ultimately improved health status of minority populations in the El Paso border region. To demonstrate the value of REAL data collection/analysis, i.e., the opportunity it presents for targeted intervention, the BPHIG project will research annual flu vaccine, Tdap booster, and lipid screening rates among minority adults then develop an intervention strategy to improve compliance with the above preventive health measures.

Relationship to Other Projects:

The Border Public Health Interest Group complements another health department DSRIP submission: El Paso Community Health Atlas (065086301.1.2), which seeks to develop a comprehensive biomarker database which can be analyzed by zip code or other geo, demographic, or health-related criteria for research and targeted interventions to address health disparities in the border region. Though sharing a common agenda for improved health of underserved populations, the two projects are distinct. The Community Health Atlas will catalog and interface existing health data sources and supplement the database with biomarker data from biosample collection/analysis initiative. The purpose of BPHIG, on the other hand, is to analyze the data for specific research objectives, i.e., the Atlas is a data repository, BPHIG mines the data for description of health status/conditions and prescription of policy and programming interventions.

Relationship to Other Performing Providers' Projects in the RHP:

The Border Public Health Interest Group also complements other DSRIP initiatives in Region 15 including:

- UMC: Enhance Performance Improvement and Reporting Capacity at UMC Neighborhood Health Centers
- UMC: Chronic Care Model for Neighborhood Health Centers
- Texas Tech: Disease Management Registry
- Tenet: Enhance Interpretation Services and Culturally Competent Care
- HCA: Chronic Disease Management Registry

Plan for Learning Collaborative:

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the delivery system for the low-income Waiver. As

noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share its experiences and challenges in implementing its DSRIP projects, but also recognizes the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare and indigent population.

Project Valuation:

The proposed value (community benefit) of the Border Public Health Interest Group (BPHIG) is $5,933,708 over the DSRIP funding period (DY 2-5). Of this amount $4,309,791 has been allocated for the value of Category 1 Infrastructure Development. The valuation takes into account direct staffing of the initiative (two epidemiologists and one support staff) adjusted for leave time use/staff turnover; supplies and materials; training and conference attendance for health department staff and BPHIG researchers; consultation for design of pilot collaborative research project; computers/tablets for field collection of data; stipends for field data collectors/researchers; technical consultation and software design/purchase for inputting and analysis of REAL data; back office functions (payables and receivables management, fiscal and program reporting, human resources); program management to troubleshoot scheduling/staffing/production issues; publication and other costs related to the dissemination of research findings; evaluative services for collection and analysis of activity and other performance data relative to DSRIP reporting requirements; and administrative oversight.

065086301.1.1	***1.5.2***	***1.5.2***	***PROJECT TITLE: BORDER PUBLIC HEALTH INTEREST GROUP***	
Performing Provider Name: City of El Paso Department of Public Health				*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.1*	*IT-11.3*	*OD-11 Addressing Health Disparities in Minority Populations* *Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity*	
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 P-4 Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Process Metric** P-4.1 Description of elements of the system Goal: Inventory and assess data collection policies and procedures of respective institutions; identify opportunities for standardization policies and procedures relative to REAL data collection Data Source: Policies and procedures Estimated Incentive Payment*:* $600,000 **Process Milestone**	**Process Milestone** P-4 Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Process Metric** P-4.1 Description of elements of the system Goal: Continue to identify opportunities for standardization of policies and procedures relative to REAL data collection; coordinate inter-institutional response to assure development and adoption of standardized REAL data collection policies and procedures Data Source: Policies and procedures Estimated Incentive Payment*:* $524,450 **Process Milestone**		**Improvement Milestone** I-12 Implement intervention to make improvements in REAL data collection and use **Improvement Metric** I-12.1 Documentation of increased number of unique patients with documented REAL data using innovative program option. Demonstrate improvement over prior reporting period (baseline for DY 2) Goal: Initiation of collaborative research project using standardized REAL data collection and analysis to increase immunization and lipid screening compliance rates among minority adults Data Source: Documentation of research project ; demonstration of REAL data collection; identification of 500 minority adults in need of flu vaccine, Tdap booster, and/or lipid	**Improvement Milestone** I-12 Implement intervention to make improvements in REAL data collection and use **Improvement Metric** I-12.1 Documentation of increased number of unique patients with documented REAL data using innovative program option. Demonstrate improvement over prior reporting period (baseline for DY 2) Goal: Continue initiative to improve preventive health services compliance rates among minority adults by identifying 750 minority adults in need of flu vaccine, Tdap booster, and/or lipid screening; provision of necessary preventive services to target population. Release of pilot research findings; discussion of value of REAL data collection relative to analysis,

065086301.1.1	***1.5.2***	***1.5.2***	***PROJECT TITLE: BORDER PUBLIC HEALTH INTEREST GROUP***	
Performing Provider Name: City of El Paso Department of Public Health				*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.1*	*IT-11.3*	*OD-11 Addressing Health Disparities in Minority Populations* *Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity*	
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)**
P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning	P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data source: Documentation of semi-		screening; provision of necessary preventive services to target population Estimated Incentive Payment*:* $525,007 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP	interpretation, and policy/program opportunities Data Source: Documentation of release of research findings Estimated Incentive Payment*:* $505,438 P**rocess Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-

065086301.1.1	***1.5.2***	***1.5.2***	***PROJECT TITLE: BORDER PUBLIC HEALTH INTEREST GROUP***	
Performing Provider Name: City of El Paso Department of Public Health				*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.1*	*IT-11.3*	*OD-11 Addressing Health Disparities in Minority Populations* *Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity*	
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: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $600,000	annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $524,450		P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $525,008	face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $505,438
Year 2 Estimated Milestone Bundle Amount: $1,200,000	Year 3 Estimated Milestone Bundle Amount: $1,048,900		Year 4 Estimated Milestone Bundle Amount: $1,050,015	Year 5 Estimated Milestone Bundle Amount: $1,010,876
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $4,309,791				

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City of El Paso Department of Public Health
DSRIP Project: El Paso Community Health Atlas

Identifying Project and Provider Information:

Title of Project: El Paso Community Health Atlas
RHP Project Identification #: 065086301.1.2
Project Option: 1.5.3 implement project to enhance collection, interpretation, and/or use of REAL data
Performing Provider Name: City of El Paso Department of Public Health/065086301

Summary Information:

Provider Description:
The Performing Provider is the City of El Paso Department of Public Health (CEPDPH). The CEPDPH has 270 employees and an annual budget of $19M. The Department provides food protection, epidemiology, preparedness, laboratory, population-based health planning, WIC, and 211 Call Center services. In addition it is a clinical provider of dental health, immunizations, tuberculosis and STDs. Our primary public health catchment area is the City of El Paso. However, we also provide services for other municipalities within El Paso County and unincorporated areas through interlocal agreements. Outside the El Paso County, there are select grant programs, e.g., WIC, where the terms of the grant require the department to serve Hudspeth County. The total population for our service region is approximately 820,000.

Intervention:
The CEPDPH is proposing a four year developmental effort to establish and use an El Paso Community Health Atlas for describing health status on the catchment area at zip code level for the benefit of the community planners, researchers, policy makers and service providers.

Description of Need:
There is currently no local/regional data repository for health information for research, policy development, and targeted interventions. Hence, no analysis of community level data gaps has been yet conducted. Health Information Exchange holds promise as a means to acquire data; however, it is limited by number of providers participating in the exchange. Further, data acquired by the exchange is patient-related, i.e., limited to those who are accessing the formal health care system. As a border community, however thousands of residents do not access healthcare systems, i.e., do not go to doctors, clinics, or hospitals; therefore, there is no way to capture de-identified data on these residents from institutional and private/public provider sources. These missing data are necessary to complete an accurate health profile of populations in the El Paso border region.

Target Population:
The Community Health Atlas project will capture health information from existing databases and supplement that data with health information acquired through deployment of a mobile health screening van. Target population for mobile health screening and biomarker data collection will be individuals who don't use the formal healthcare system, e.g., low income, uninsured.

Benefit to Medicaid/Indigent Patients:
Capturing REAL data on all elements of the El Paso region's population, e.g., insured and uninsured, system users and non-users, is critical to understanding health needs and developing interventions.

Through the Community Health Atlas, health planners and health care providers will better understand the needs of specific populations and where those needs present. Targeting interventions to specific areas of need (location and groups) will allow for more efficient use of resources; and improve the likelihood of policy/program support for service expansion.

Medicaid/uninsured residents are prone to underutilize outpatient clinical preventive services. Rather, they access the system only at point of illness and often through inappropriate venues, e.g., emergency room for non-emergent care. Creation of the regional data repository will facilitate collection and analysis of REAL data on Medicaid/uninsured residents which will be used to increase compliance with clinical preventive services interventions. The health department proposes to interface the Community Health Atlas initiative with the Border Public Health Interest Group proposal (065086301.1.1) to identify 1,250 Medicaid/uninsured residents in need of one or more clinical preventive services (annual flu vaccine, Tdap booster, and/or lipid screening) then assure that these selected high risk patients receive timely and appropriate preventive services.

Expected Benefit of Project:
Category 1 Milestones: Inventory data sources; identify opportunities for standardization of REAL data collection; prepare business plan for capturing de-identified data from multiple repositories; procure and deploy mobile health screening van for collection of biomarker data; develop/refine reporting formats
Category 3 Outcome Measures: Apply Atlas data to development of a targeted intervention for episodic/chronic disease prevention/management in specific zip code(s) in the El Paso area; use Atlas to describe conditions; inform policy makers and health care providers; sensitize and educate the community; and motivate target population for action. Demonstrate value of REAL data collection and analysis by evaluating relationship between increased use of clinical preventive services for Medicaid/self-pay and corresponding reduction in preventable hospital admissions

Project Description:
To achieve efficiency on health policy and clinical practice timely and accurate population gathering and reporting systems are needed to guide the community care systems as to: 1) where funds and efforts should be should focused in order to achieve the most leveraged return; and 2) whether or not progress is being achieved. Like many communities, El Paso lacks a user-friendly healthcare data repository where the proposed El Paso Community Health Atlas, addresses that need and will produce a comprehensive database that stores and distributes healthcare relevant information, including biomarker information linked to zip codes, to establish a baseline against which future data can be compared. Biomarkers are measurable characteristics that reflect the severity or presence of some disease state. They include information like blood pressure, cholesterol levels, body-mass index, and others which are extremely important in assessing the state of health, the progress (or ineffectiveness) of strategies, and the risk of occurrence of more serious conditions. Linking this biomarker data, with other types of data to zip code, i.e., locations, allows an even greater ability to focus resources on improving health for residents in areas where the data indicate the risk of worsening. El Paso has numerous unlinked data repositories housed within a variety of organizations and institutions, private and public, all storing information about the health and disease and risk of disease of their respective client populations. In order to establish the infrastructure that will enable policy leaders to make outcome-driven decisions, this project proposes a four-year effort that comprises the following key project activities:

1) Identify organizations that collect health-related data with the end goal of establishing the ongoing mechanisms for accessing the specific information required for this project;

2) analyze the data with the end goal of identifying gaps of information that need to be further surveyed, along with reporting on the trends and patterns revealed by the analysis;
3) Finalize the measurement of biomarkers and reporting of combined data sources to be utilized by the project's policy and practice group; and,
4) Utilizing the data reported, determine the interventions to be undertaken in specific geographic areas which have the ability to provide the largest return on investment.

Goals and Relationship to Regional Goals

The overarching goal of this project is to assess data resources, index data by category and map this data by zip code to provide better insight into the health of the populations and sub-populations of El Paso. The ability to access data in a user friendly fashion by researchers, policy makers, public health surveillance teams, service providers and others will effectively lead to improved local understanding of the community needs and ways to improve outcomes (clinical, financial, quality and satisfaction). Population-based data collection and research in the El Paso community will help describe/refine who's at risk for select diseases by race, ethnicity, language (REAL), physiologic, behavioral, socioeconomic and other factors and who may be protected by one or more of the above factors. Further, specific interventions can be studied to identify best practices for disease prevention/management/control in a predominantly Hispanic population. The Health Atlas will inform/and influence health planners, clinicians, and policy makers and, therefore, is translational to all DSRIP health improvement categories.

Project Goals:

To achieve the goal of population health improvement, the collection, synthesis, and use of geographic information as it relates to the multidimensionality of health offers a starting point. This project is aimed at assessing what data are available, the types of data, where the data reside, and gaps of data. Data will be geo-referenced to delineate spatial clusters of: (a) Infectious disease; (b) Chronic Disease; and (c) Risk factors for disease.

- Represent health data with geographic associations; investigate patterns of disease.
- Use spatial estimates to transform health data into surface of disease visualizations.
- Create a portal that can be accessed by the public which provides data alerts.
- Create one data repository from the following data categories (health behavior, clinical care (locations of care sites), social and economic, safety (police/fire), physical environment (parks, recreational facilities, grocery stores, restaurants, and air and water quality).

This project meets the following regional goals:

The Atlas project will provide key statistics, profiles with contextual information and interactive mapping which allows even non-technological users to easily visualize and identify selected areas and themes with ease. Having this powerful resource online means users are able to target existing resources supporting the evidence-base for policy and community related interventions. It also will allow users to search data by theme, geography, list name of indicators, compare areas or search for individual themes. This aligns with regional goals of:

- Overcome language, socio-economic, and monetary barriers to accessing healthcare resources in the region (This is achieved by not only having access to data available if a person is part of current data collection but to reach out to populations we do not have data on and obtain biomarkers.)
- Better manage patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, and Renal disease to help prevent unnecessary readmission and get patients the care they need to

prevent, self-manage, and address in an appropriate setting. Provide patient education to ensure the population is accessing the right care in the right setting (Data will show by diagnosis code and number of encounters where people and accessing care, as well as the payer mix, zip code of their place of residence, and more. Researchers and others can identify particular high risk populations and possible reasons for inappropriate utilization such as inability to obtain an appointment at clinics in the area, transportation issues, poor health literacy, lack of understanding regarding what is available in their community as resources, etc.)

Challenges:

The challenges associated with creating a centralized data warehouse range from collaboration amongst parties; clear agreement on data to be used; how data will be transmitted; security of data transmission; integrity of data; ; and who will have access to data. These challenges can be overcome by having a clear plan on indexing what is an available today; assessing gaps in data; and having experienced experts involved in the design of the model that facilitates data exchanges without additional work to participants in a secure platform.

Five Year Expected Outcome for Providers and Patients:

Over a five year work period the Atlas will demonstrate how access to relevant health indicators in a centralized easy to use format will provide the information needed to prioritize and coordinate needed activities to improve population health. The expectation is that there will be:

1. Improved awareness around the status of health in the region by zip code
2. Enhanced understanding of influencers of health
3. Greater coordination amongst stakeholders in efforts to improve health Demonstrated value of the Atlas through using the repository to identity high risk individuals with deficiencies in clinical preventive services then assuring provision of said services

Starting Point Baseline:

This is a new initiative of the city of El Paso Department of Public Health; hence, baseline is zero (0)

Rationale:

Previously, policy makers, organizations, and consumers based decisions impacting health on minimal data and good guesses around what was needed and interventions that may make a difference in improving the health of an individual or population. We have an enormous opportunity to not only gather and analyze data to make better informed decisions about what is needed to improve health, but to also utilize resources more wisely and cost effectively to eliminate wasteful spending. Public health should engage community stakeholders and expand the capacity of a community to come together and identify ways to work together towards building a healthier community.

Currently, the exchange of data in health care is being supported by the “Meaningful Use” initiatives by both Medicare and Medicaid for hospitals and health practitioners. The first stage of the Hi-tech Iteration involves the capture and sharing of data electronically. Next is Stage 2 which is aimed at connecting the community and sharing data interorganizationally. Further connecting the person, integrating data, and creating executable knowledge, Stage 3 and beyond intent is to build learning models of health preservation and treatment (improved outcomes) (Intiative, 2012). Meaningful Use is also tightly tied to the Accountable Care Organizations as we better understand the population by mining data we can identify opportunities for improvement which can lead to better outcomes in a cost effective way and share in the savings and risk. The project is also tightly aligned with the Institute of Medicine’s work on the biomarker evaluation in health care which includes analytical validation, qualification, and utilization and

recommendations for implementing the framework for supporting evidence based decisions and promotion of public health. The evaluation framework is constructed based on the following questions: (1) can the biomarker be appropriately measured, (2) is the biomarker associated with the clinical endpoint of concern, and (3) what is the specific context of the proposed use (Medicine, 2010). The rationale behind this project is to:

- Build sustainable and long term workflows to improve knowledge.
- Build an infrastructure for gathering existing data
- Integrate biomarkers measures with other data sets
- Establish connectivity amongst partners
- Deploy a central repository and informatics tools
- Develop strategies for wellness and prevention
- Obtain baseline data and outcomes measures; develop reporting tools
- Gain real-time surveillance
- Integrate longitudinal data and create knowledge
- Increase data transparency

Project Components:

1.5.3 a) Redesign pathways to collect REAL data at point of care

- Review organizations and data resources available at the county and city level, community organizations, hospitals, FQHCs, Public Safety (Police and Fire) Environmental projects, etc.
- Compile and review data domains. These include but are not limited health behavior, clinical care, social and economic factors, as well as physical environment in context of REAL data collection
- Compile an index of organizations in the city and county; assess the role they play in the community, and services provided.
- Conduct a data review of the above organizations to identify what data to include in a data repository. A middleware company will be contracted to assist in identifying ways in which to export data from various systems compliant with HIPAA and security protocols which do not present undue workloads on the participating organizations. The frequency of data exchange will also be determined in order to provide just in time information for analyses.

1.5.3 b) Implement system to stratify patient outcomes and quality measures by REAL data

- Identify and report trends and patterns. Gaps of REAL data information will be identified and prioritized for further survey by the project search group.
- Based on observed trends and patterns, prioritize zip codes to begin sampling of biomarkers measurement to supplement REAL data from other sources. The final goal is to perform statistically significant sampling of all zip codes for comparative analyses to identify “hot spots” for disparities; rank order zip codes by severity and scope of problems; and recommend targeted interventions.

1.5.3 c) Develop improvement plans to address root causes of disparities

- Analyze REAL data sets for positive outcomes as well as presence of problem conditions by population characteristics.
- Conduct comparative analyses of populations with/without problem conditions to identify similarities and differences
- Drill down data from above analyses to identify significant demographic, behavioral, social, environmental factors which are predictive of positive health outcome
- Design intervention strategies to educate community on positive outcome predictors/replicate

positive factors

1.5.3 d) Use data to undertake interventions aimed at reducing health/health care disparities

- Determine interventions for specific geographic areas which will provide the largest return on investment for advancement of health standards/goals and change in health status
- Gather community/patient feedback on prioritization of problems/geographic areas to inform decision makers and intervention planners
- Develop, use and maintain ongoing evaluative (feedback) loop to sustain community interest/investment

Unique community need and identification number(s) the project addresses:

CN.4 Obesity Prevention/Health Promotion

CN.6 Other Community Need as Identified by the Performing Provider

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

Currently, there is not a coordinated approach in the collection, synthesis and use of geographic information as it relates to the multidimensionality of health. There are, however, databases available on the state and county level; but nothing that brings this down to smaller more targeted detail. The Atlas will provide a means for all stakeholders to access data to identify needs and trends and develop effective targeted interventions.

Related Category 3 Outcomes Measure(s):

Outcome Domain (OD-11): Addressing Health Disparities in Minority Populations

Improvement Targets) IT 11.3 Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity

Reason/Rationale for selecting the outcomes measure(s):

There is currently no local/regional data repository for health information for research, policy development, and targeted interventions. No analysis of community level data gaps has been conducted. As a border community, thousands of residents do not access the formal healthcare system; hence, there is no way to capture de-identified data on these residents from institutional and private/public provider sources. These missing data are necessary to complete an accurate health profile of populations in the El Paso border region. To demonstrate the value of REAL data collection/analysis, the BPHIG project will research annual flu vaccine, Tdap booster, and lipid screening rates among minority adults then develop an intervention strategy to improve compliance with the above preventive health measures.

Relationship to Other Projects:

The El Paso Community Atlas complements the health department's the Border Public Health Interest Group (BPHIG) (065086301.1.1) submission which seeks to analyze REAL data to describe regional/local health problems and develop appropriate policy and program interventions. Though sharing a common agenda for improved health of underserved populations, the two projects are distinct. The Community Health Atlas will catalog and interface existing health data sources and supplement the database with biomarker data from biosample collection/analysis initiative. The purpose of BPHIG, on the other hand, is to analyze the data for specific research objectives, i.e., the Atlas is a data repository, BPHIG mines the data for description of health status/conditions and prescription of policy and programming interventions.

Relationship to Other Performing Providers Projects in the RHP:

The El Paso Community Atlas complements other DSRIP initiative's in Region 15 including:

HCA: Chronic Disease Management Registry

Texas Tech: Disease Management Registry

UMC: Chronic Care Model for Neighborhood Health Centers

Plan for Learning Collaborative:

The Anchor for Region 15 (UMC), performing providers, and IGT entities has held consistent monthly meetings throughout the development of the 1115 waiver projects. As noted by HHSC and CMS, meeting and discussing waiver project successes and challenges facilitates open communication and collaboration among participants. We plan on using various channels of communication moving forward including but not limited to: (1) conference calls; (2) online and physical meetings; (3) newsletters; and (4) conferences to provide a means to share ideas, experiences, and identify ways in which to continually improve programs and efforts. It is imperative that data projects come together and discuss what is being collected and how, as well as engaging with the larger group to ensure the project activities are known to them and that we are working together to ensure appropriate use of resources and provide communication and dissemination of information on project goals and timelines.

UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and breaking the larger group into Learning Collaboratives that meet on a more frequent basis to address specific DSRIP project areas, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which includes the regional projects listed by Performing Provider, contact information of each participant, as well as minutes, notes, slides and HHSC information. The Atlas project plans on having a web site which will provide the participants, anchor, and community a means to engage in the project. The site will have a calendar activities and conferences in which the project will participate, videotaped presentations, a Gantt chart on the tasks to be undertaken and timeline progress, as well as resources identified. It is our plan to work together with other participant's to organize at a minimum an annual conference for the region, as well as gather annually with state wide entities to share experiences and challenges in implementing projects. These activities can lead to better leverage of assets and knowledge to improve processes, obtain a fresh look at what you are doing today and identify best practices that may apply to the population served.

Project Valuation:

The proposed value (community benefit) of the El Paso Community Health Atlas is $4,746,967 over the DSRIP funding period (DY 2-5). Of this amount $3,760,225 has been allocated for the value of Category 1 Infrastructure Development. The valuation takes into account direct staffing of the initiative (project director, epidemiologists and support staff); supplies and materials; training/conference attendance for health department staff and Atlas researchers; consultation for design of pilot collaborative research project; computers/tablets for field collection of data; stipends for field data collectors/researchers; technical consultation and software design/purchase for inputting and analysis of REAL data; back office functions (payables and receivables management, fiscal and program reporting, human resources); program management to troubleshoot scheduling/staffing/production issues; publication and other costs related to the dissemination of research findings; evaluative services for collection and analysis of activity and other performance data relative to DSRIP reporting requirements; and associated capital purchases: procurement and/or retrofitting of mobile health screening van, outfitting of van with appropriate specimen collection and diagnostic equipment for biomarker initiative; and the community benefit value of collecting and conducting research on REAL data to describe/refine area health problems with the intent of informing

the community of findings; building community constituencies for policy change and program development; and prescribing evidence-based interventions.

065086301.1.2	*1.5.3*	*1.5.3 A-D*	*PROJECT TITLE: EL PASO COMMUNITY HEALTH ATLAS*
Performing Provider Name: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.2*	*IT 11.3*	*OD-11 Addressing Health Disparities in Minority Populations* *Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity*

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 P-4 Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Process Metric** P-4.1 Description of elements of the system Goal: Inventory data sources; identify gaps in geo-coded data; identify opportunities for standardization of REAL data collection; develop policies, as needed; develop business plan for collection of biomarker data; spec equipment, supplies, furnishings for mobile health unit for collection of de-identified biomarker data Data Source: Policies and procedures; evidence of business plan Estimated Incentive Payment: $475,000 **Process Milestone**	**Process Milestone** P-4 Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Process Metric** P-4.1 Description of elements of the system Goal: Continue data source inventory; identify gaps in geo-coded data; identify opportunities for standardization of REAL data collection; develop policies, as needed; refine business plan for collection of biomarker data; procure mobile health unit and related equipment, supplies, furnishings for collection of de-identified biomarker data. Recruit/retain staff for field deployment for collection of biomarker data; initiate data collection Data Source: Policies and procedures; evidence of business plan, fully furnished/deployable health screening van. Availability of	**Improvement Milestone** I-12 Implement intervention to make improvements in REAL data collection and use **Improvement Metric** I-12.1 Documentation of increased number of unique patients with documented REAL data using innovative program option. Demonstrate improvement over prior reporting period (baseline for DY 2) Goal: Continuation of de-identified biomarker data collection; interface collected data with other data sources/systems; develop reporting formats; analyze and report health status data by zip code. Integrate data repository with Border Public Health Interest Group demonstration research project to increase immunization and lipid screening compliance rates among minority adults. Data Source: Evidence of biomarker data collection, analysis, and	**Improvement Milestone** I-12 Implement intervention to make improvements in REAL data collection and use **Improvement Metric** I-12.1 Documentation of increased number of unique patients with documented REAL data using innovative program option. Demonstrate improvement over prior reporting period (baseline for DY 2) Goal: Continuation of de-identified biomarker data collection/analysis; interface collected data with other data sources/systems; refine reporting formats; develop tailored reports for healthcare providers, policy makers, and general public; report health status data by zip code. Continue initiative to improve preventive health services compliance rates among minority adults by using the Atlas to identify 750 minority adults in need of flu vaccine, Tdap booster, and/or

065086301.1.2	*1.5.3*	*1.5.3 A-D*	*PROJECT TITLE: EL PASO COMMUNITY HEALTH ATLAS*
Performing Provider Name: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.2*	*IT 11.3*	*OD-11 Addressing Health Disparities in Minority Populations* *Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity*

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)**
P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence	staff. Estimated Incentive Payment: $434,670 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at	reporting. Identification of 500 minority adults in need of flu vaccine, TDAP booster and/or lipid screening; provision of necessary preventive services to target population Estimated Incentive Payment: $465,005 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP	lipid screening; provision of necessary preventive services to target population Estimated Incentive Payment: $505,438 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP

065086301.1.2	***1.5.3***	***1.5.3 A-D***	***PROJECT TITLE: EL PASO COMMUNITY HEALTH ATLAS***
Performing Provider Name: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.2*	*IT 11.3*	*OD-11 Addressing Health Disparities in Minority Populations* *Improve Utilization Rates of Clinical Preventive Services in Target Population with Identified Disparity*

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 "raise the floor" initiative. Estimated Incentive Payment: $475,000	the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $434,670	P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $465,004	P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $505,438
Year 2 Estimated Milestone Bundle Amount: $950,000	Year 3 Estimated Milestone Bundle Amount: $869,340	Year 4 Estimated Milestone Bundle Amount: $930,009	Year 5 Estimated Milestone Bundle Amount: $1,010,876
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,760,225			

95789

City of El Paso Department of Public Health
DSRIP Project: Expansion of Oral Health Services

Identifying Project and Provider Information:

Title of Project: Expansion of Oral Health Services
RHP Project Identification #: 0065086301.1.3
Project Option: 1.8.7 The expansion or establishment of satellite mobile dental clinics with an affiliated fixed-site dental location.
Performing Provider Name: City of El Paso Department of Public Health/065086301

Summary Information:

Provider Description:

The Performing Provider for this project is the City of El Paso Department of Public Health. The Department of Public Health has 270 employees and an annual budget of $19M. The department provides food protection, epidemiology, preparedness, laboratory, population-based health planning, WIC, and 211 Call Center services. In addition, the department is a clinical provider for dental health, immunizations, tuberculosis control, and STD diagnosis and treatment.

Primary catchment area for the public health department is the City of El Paso. The health department provides services for other municipalities within El Paso County and the unincorporated area through interlocal agreements. Finally, there are select grant programs, e.g., WIC, where the terms of the grant require the department to serve Hudspeth County. Total population for the service region is approximately 820,000.

Intervention:

The City of El Paso Department of Public Health proposes to expand access to dental care for low income children and pregnant women in the El Paso area by acquiring, outfitting, staffing, and deploying a mobile dental clinic to underserved areas/populations outside of the current catchment area of the department's fixed-site Rawlings Dental Clinic.

Through this DSRIP initiative, the health department is proposing to expand dental services for low income children and pregnant women through acquisition, staffing and deployment of a mobile dental clinic. The mobile dental van would visit Ft. Bliss, area schools; the health department's 15 WIC sites; Texas Tech general medicine, pediatric and obstetrics clinics; and frequented commercial properties in low income areas. Services would include screening/exam, cleaning, sealants, and restorative care.

Following purchase and outfitting of the mobile clinic; employment of staff; and deploying the unit, the health department plans to enroll (exam/treat) 500 additional children/pregnant women in the first year and 250 additional per year for DY4 and DY5 for a total of 1,000 additional patients over the DY3-5 period. Further, upon completion of initial exam and restorative care, proper oral health maintenance should result in a 40% reduction in the number of patients needing additional restorative work by DY5.

Description of Need:

El Paso is a poor county. About 25% of its residents live at or below the federal poverty level. This exceeds the poverty rate for Texas of 17%, which is the sixth highest in the nation. Poor people, especially working poor, are often uninsured, as well. Twenty-eight percent of El Paso's population has no health insurance which, again, exceeds the state rate of 24%. Given the low per capita income in El Paso and the likelihood that dental insurance is an employee-paid option, the uninsured rate for dental care is probably significantly higher than 28%.

Exacerbating the access problem is El Paso's dentist shortage. The El Paso area would have to double its supply of dentists to meet national coverage levels. Given the poverty of its population and dearth of insurance coverage, several hundred dentists will not relocate to El Paso, i.e., the problem will not self-correct through normal market forces.

Target Population:

The proposed dental service expansion will provide dental care to low income children and pregnant women who have little, if any, access to private dental care. The mobile dental clinic will target areas in the region with high Medicaid and/or uninsured rates and few dental providers.

Benefit to Medicaid/Indigent Patients:

Preventive and restorative services will be provided to vulnerable populations using an appointed schedule. The Mobile Dental Clinic will be deployed to areas of high need on scheduled basis. Prospective patients will be identified through a collaborative casefinding process with local schools and help agencies.

The mobile dental van will provide a dental home for Medicaid children and will serve as a source of oral health assessment and referral, as needed, to dental specialists and/or physicians. The dentists and other health professionals associated with the mobile dental clinic will assess health status and refer patients to other healthcare providers, as needed, thereby compounding the positive health benefit from the project.

Expected Benefit of Project:

Category 1 Milestones: Identify/cultivate potential referral sources for low income children and pregnant women; develop referral protocols; procure/outfit mobile dental clinic; recruit staff; deploy unit per schedule.

Category 3 Outcome Measures: Provide preventive/restorative care for an additional 1,000 low income children and pregnant women over the DY3-5 period. Forty percent (40%) reduction in patients needing further restorative work by DY5.

Project Description:

El Paso is poor area with low wages. Dental insurance, the means to accessing private dental care, is either unavailable or unaffordable. The City of El Paso Department of Public Health is proposing to expand oral health services for low income children in the El Paso area by acquiring a mobile dental van and deploying the van to underserved communities with limited or no access to private dental care. Expanding access through the mobile dental van will help close gaps/disparities in access to dental care services.

Goals and Relationship to Regional Goals:

The goal of this project is to expand access to preventive and restorative dental care for low income children in the greater El Paso area who have limited, if any, access to private dental care. Many of these children live in densely populated urban areas with few private dentists (due to prevailing low income status of the residents). Others live in rural communities or isolated areas with no private dentists. A mobile dental van would improve access to dental care for these populations and maximize economic efficiencies of service delivery, i.e., avert the overhead (facility/staff) of multiple, low volume fixed-site dental clinics.

Project Goals:

- Identify organizations/institutions which will collaborate with planners on finding/referring children in need of subsidized dental care
- Acquire a shell vehicle for conversion to mobile dental clinic
- Outfit the shell vehicle with equipment, furnishings, and supplies for a dental clinic
- Recruit/hire a team of dentist, hygienist, assistants, and clerk
- Further develop relationships with patient referral sources to identify those willing to assist with van deployment logistics
- Develop a deployment schedule for the mobile dental clinic
- Initiate mobile dental service
- Assess effect of service on overall health status of served children

This project meets the following regional goals:

The Mobile Dental Clinic project will enhance service capacity for vulnerable populations in the greater El Paso area. The project relates to the following regional goals:

- Overcome language, socio-economic, and monetary barriers to accessing healthcare resources in the region
- Provide the full continuum of healthcare services, from wellness to preventative care, to emergent care, to disease management, to palliative and hospice care
- Increase the number of specialists and scope of services offered in the community

Challenges:

The major challenges for the Mobile Dental Clinic will be building/retaining a team of providers and assuring that service volume is commensurate with financial investment and community expectations. Public health dental clinic can be a difficult practice setting given patient acuity/complications/compliance issues with preventive practices. Further, the dental team will have to work in a confined setting for extended periods of time. Forming and preserving a “team” attitude will be critical to achieving service goals. Also, public health dental clinics have inordinately high no show rates which necessitate overbooking of appointments and alternative booking arrangements, e.g., dedicating the morning to a busload of Head Start kids. Mobile Dental Clinic planners will need to build referral source support/commitment prior to deployment of the unit so that quality services can be provided efficiently by the mobile dental clinic team.

5 Year Expected Outcome for Provider and Patients:

Over the 5 year work period the Mobile Dental Clinic will provide much-needed preventive and restorative dental care for thousands of low income children in the El Paso border region. In addition to providing dental services, the mobile dental clinic will serve as casefinder for other health department and community programs which can facilitate good health, e.g., Supplemental Food Program for Women, Infant, and Children (WIC).

Starting Point Baseline:

This is a new initiative; hence baseline number of clients is zero (0).

Rationale:

For many of El Paso's low income children and adults dental health is a low priority. With no experience going to the dentist for checkups and cleaning and a multitude of competing needs for their limited resources, many low income residents seek dental care only for relief of severe pain and, often, at the point of tooth extraction. In addition to the negative effect on self-image, this tooth loss impairs eating; affects nutrition; and causes or worsens chronic health conditions.

Fortunately, good dental health is now being recognized an essential element of physical, psychological, and social well-being. With this heightened awareness of the role of oral health comes the expectation that communities will address the clinical dental needs of low income populations.

El Paso is a poor county. About 25% of its residents live at or below the federal poverty level. This exceeds the poverty rate for Texas of 17%, which is the sixth highest in the nation. Poor people, especially working poor, are often uninsured, as well. Twenty-eight percent of El Paso's population has no health insurance which, again, exceeds the state rate of 24%. Given the low per capita income in El Paso and the likelihood that dental insurance is an employee-paid option, the uninsured rate for dental care is probably significantly higher than 28%.

Contributing to the access problem is El Paso's shortage of dentists. With a population to dentist ratio of 3,330:1, El Paso's supply of dentists is only 65% of the statewide coverage level and 49% of the national rate. El Paso would have to recruit an additional 163 dentists just to reach Texas coverage. The El Paso area would have to double its supply of dentists to meet national coverage levels. Given the poverty of its population and dearth of insurance coverage, several hundred dentists will not relocate to El Paso, i.e., the problem will not self-correct through normal market forces.

Fortunately, the City of El Paso Department of Public Health operates a fixed-site dental clinic in an underserved area in central El Paso. The Rawlings Dental Clinic provides preventive and restorative care to 4,000 low income children per year. But the clinic draws most of these patients from its immediate catchment area (about1-3 mile radius). There are thousands of low income children who live outside the catchment area and are not accessing dental services.

As expected, most of the 235 dentists in El Paso County practice in the urban area of the City of El Paso. Hence, the small towns and unincorporated area of the county have few, if any, dentists. This mal-distribution of dentists exacerbates the access problems for rural residents.

The initiative will include a quality improvement plan with continuous feedback from clients and

service site/referral personnel. Results from feedback will inform dental clinic staff on site selection/scheduling of van, scope/volume of service, and dental staff/patient interaction. Further, dental staff will collaborate with other information sources in the community to assess impact of the expanded dental service on oral health of the service population and related social conditions.

Project Components:

There are no specific project components to Project Option 1.8.7; however, the project option does require quality improvement activities including "lessons learned," and identifying opportunities for scaling and replication of successful interventions. The Mobile Dental Clinic project staff/planners will conduct an ongoing quality improvement process to address the requirements of this section.

Unique community need identification number(s) the project addresses:

CN.1 Primary Care
CN.6 Other Community Need as Identified by the Performing Provider

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

There is currently no strategically planned/deployed mobile dental clinic in the El Paso area. The limited existing capacity to provide mobile dental services is prone to equipment problems and is either under-staffed and/or under-utilized. With appropriate due diligence on referral source development, staffing, and deployment, the health department's mobile dental clinic will add critical capacity to dental resources in the community and perform its function in a fiscally responsible manner.

Related Category 3 Outcome Measures:

Outcome Domains (OD-7): Oral Health

> Improvement Targets IT-7.2 (DY 4-5): Cavities: Percentage of children with untreated dental caries

Reasons/Rationale for selecting the outcome measures:

The outcome of the proposed Mobile Dental Clinic DSRIP project will be improved oral health among low income children in underserved urban and rural communities in the El Paso area. Specific improvement targets will be developed as staff analyzes production potential and refines service sites, scheduling, and staffing to maximize community health improvement effect of the mobile dental clinic, i.e., increasing services to vulnerable populations and reducing attendant health disparities. It is expected that following initial exam and treatment, there will be an improvement in oral health practices resulting in a reduction in the need for further restorative care.

Relationship to Other Projects:
NA

Relationship to Other Performing Providers' Projects in the RHP:

NA

Plan for Learning Collaborative:

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the delivery system for the low-income Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share its experiences and challenges in implementing its DSRIP projects, but also recognizes the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare and indigent population.

Project Valuation:

The proposed value (community benefit) of the mobile dental van initiative is $5,933,709 over the DSRIP funding period (DY 2-5). Of that amount $4,921,967 has been allocated for Category 1 Infrastructure Development. The valuation takes into account acquisition and outfitting of a mobile dental clinic (amortized over the funding period); direct staffing of the van adjusted for leave time use/staff turnover; supplies/materials/maintenance; back office functions (billing/reporting/human resources); program outreach to assure continuous, productive service sites; program management to troubleshoot scheduling/staffing/production issues; evaluative services for collection and analysis of service/client data relative to planned activity/performance; and administrative leadership. The valuation also reflects additional costs of providing care through a mobile dental clinic v. fixed-site location, e.g., downtime associated with moving the van to multiple sites/van setup results in less production relative to personnel and operating expenses than fixed site. Finally, the valuation estimates the cost avoidance/health status enhancement of providing a regular source of dental care to populations with no prior access to service, e.g., effect of retention of all permanent teeth on improved nutritional intake.

065086301.1.3	1.8.7	1.8.7 (	PROJECT TITLE: EXPANSION OF ORAL HEALTH SERVICES	
Performing Provider Name: City of El Paso Department of Public Health				TPI: 065086301
Related Category 3 Outcome Measures	065086301.3.3	IT-7.2	OD-7 Oral Health Cavities: Percentage of Children with Untreated Dental Caries	

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 P-6 Implement/expand alternative dental care delivery systems to underserved populations **Process Metric** P-6.1 Implement/expand a mobile dental clinic program with an affiliated fixed-site dental location Goal: Acquire/outfit a mobile dental clinic; recruit provider team; conduct due diligence on referral sources, deployment logistics, scheduling, planned production Data Source: completion of van purchase/outfitting; employment of staff; multi- year business plan for mobile dental services Estimated Incentive Payment: $587,500	**Process Milestone** P-6 Implement/expand alternative dental care delivery systems to underserved populations **Process Metric** P-6.4 Implement program to increase dental services to improve maternal and early child oral health Goal: Develop effective casefinding/referral protocol for WIC clients in need of subsidized dental care through mobile dental clinic; develop effective casefinding/referral protocol for OB clients at Texas Tech maternity clinics who are in need of subsidized dental care through mobile dental clinic. Enroll 500 patients. Data Source: Documentation of casefinding/referral protocol with WIC and Texas Tech. Activity records. Estimated Incentive Payment: $579,560	**Improvement Milestone** I-14 Increase number of special population members that can access dental services by 250 **Improvement Metric** I-14.1 Increasing the number of children, special needs patients, pregnant women and/or elderly accessing dental services I-14.2 Increasing the number of children receiving dental sealants Goal: Increase number of low income children who receive preventive (cleaning and sealants) and restorative dental care Data Source: Service statistics from Mobile Dental Clinic. Estimated Incentive Payment: $620,006	**Improvement Milestone** I-14 Increase number of special population members that can access dental services by 250 **Improvement Metric** I-14.1 Increasing the number of children, special needs patients, pregnant women and/or elderly accessing dental services I-14.2 Increasing the number of children receiving dental sealants Goal: Increase number of low income children who receive preventive (cleaning and sealants) and restorative dental care Data Source: Service statistics from Mobile Dental Clinic. Estimated Incentive Payment: $673,917

065086301.1.3	1.8.7	1.8.7 (	PROJECT TITLE: EXPANSION OF ORAL HEALTH SERVICES
Performing Provider Name: City of El Paso Department of Public Health			TPI: 065086301
Related Category 3 Outcome Measures	065086301.3.3	IT-7.2	OD-7 Oral Health Cavities: Percentage of Children with Untreated Dental Caries

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 P-10 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-10.1 Participate in semi-annual face-to-face meetings organized by the RHP P-10.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings;	**Process Milestone** P-10 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-10.1 Participate in semi-annual face-to-face meetings organized by the RHP P-10.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings;	**Process Milestone** P-10 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-10.1 Participate in semi-annual face-to-face meetings organized by the RHP P-10.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of	**Process Milestone** P-10 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-10.1 Participate in semi-annual face-to-face meetings organized by the RHP P-10.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of

065086301.1.3	1.8.7	1.8.7 (	PROJECT TITLE: EXPANSION OF ORAL HEALTH SERVICES	
Performing Provider Name: City of El Paso Department of Public Health				TPI: 065086301
Related Category 3 Outcome Measures	065086301.3.3	IT-7.2	OD-7 Oral Health Cavities: Percentage of Children with Untreated Dental Caries	
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)**
evidence of adopted "raise the floor" initiative Estimated Incentive Payment: $587,500	evidence of adopted "raise the floor" initiative Estimated Incentive Payment: $579,560		semi-annual face-to-face meetings; evidence of adopted "raise the floor" initiative Estimated Incentive Payment: $620,006	semi-annual face-to-face meetings; evidence of adopted "raise the floor" initiative Estimated Incentive Payment: $673,918
Year 2 Estimated Milestone Bundle Amount: $1,175,000	Year 3 Estimated Milestone Bundle Amount: $1,159,120		Year 4 Estimated Milestone Bundle Amount: $1,240,012	Year 5 Estimated Milestone Bundle Amount: $1,347,835
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,921,967				

95775

City of El Paso Department of Public Health
DSRIP Project: Automated Emergency Dispatch System

Identifying Project and Provider Information:

Title of Project: Automated Emergency Dispatch System
RHP Project Identification #: 065086301.1.4
Project Option: 1.10.2 Enhance Improvement Capacity through Technology
Performing Provider Name: City of El Paso Department of Public Health/065086301

Summary Information:
Provider Description:
The Performing Provider for this project is the City of El Paso Department of Public Health. The Department of Public Health has 270 employees and an annual budget of $19M. The department provides food protection, epidemiology, preparedness, laboratory, population-based health planning, WIC, and 211 Call Center services. In addition, the department is a clinical provider for dental health, immunizations, tuberculosis control, and STD diagnosis and treatment.
Primary catchment area for the public health department is the City of El Paso. The health department provides services for other municipalities within El Paso County and the unincorporated area through interlocal agreements. Finally, there are select grant programs, e.g., WIC, where the terms of the grant require the department to serve Hudspeth County. Total population for the service region is approximately 820,000.

Intervention:
The City of El Paso Department of Public Health through the El Paso Fire Department proposes to expand quality improvement through technology so that resources can enhance performance, improvement, and reporting capacity of the 911 radio dispatch system by upgrading to an automated dispatch system.

In 2012 the Fire Department's Emergency Medical Services responded to 41,215 incidents. Fifty percent of those runs (20,435) involved Medicaid and uninsured patients. Forty-seven percent (47%) of all calls were for general medical complaints. When calling 911 for a medical emergency or any other emergency, a quick response is expected. Emergency Medical Care response in the El Paso region currently occurs at 13:24 minutes. Studies show that the chances of survival are reduced 7%-10% with every minute that passes without ALS intervention.

The automated dispatch system will help improve triaging of calls; deployment of proper resources; and response time. Through this DSRIP initiative (Project option 1.10.2) the health/fire department is proposing to enhance the 911 dispatch system to the El Paso region. This technology has been noted to reduce dispatch times by 35-37 seconds. With the help of the computer aided dispatch (CAD) system and Pro Q A, times from caller to arrival shall decrease. This will affect patient's survivability, and quality of life. This initiative will include direct improvement to the automated dispatch system as well as to reducing dispatching times. Over the course of the demonstration, response times will be reduced by an average of fifteen (15) seconds.

The initiative will include a roll out plan to stations and apparatus in the region; hardware and software will also be included in the upgrade policy. The plan will include measures and targets for new response times as well and including process improvement possibilities that will work in conjunction with the new automated dispatch system.

These system enhancements will reduce institutional healthcare costs as well as improve health status for all users; however, given the disproportionate use of Emergency Medical Services by Medicaid and uninsured populations, those populations will derive added benefit from the system change

As noted above, approximately 41,000 medical runs are provided per year. A continuation of this level of activity is anticipated for the duration of the waiver, i.e., there will be about 41,000 runs per year for each year of the waiver DY2-DY5.

Description of Need:
During multiple incidents and receiving 911 calls, dispatch experiences a back log of dispatches (stacked calls). This is due to having to communicate with each unit independently. These combined actions increase the extended time of dispatching emergency apparatus to an incident creating longer response times. The processing delays are attributable to the City of El Paso currently using a manual, analog 800 MHZ trunked dispatching radio system. At present time, the system requires 9 to 11 call takers to process phone calls. These delays increase response time and could have a negative effect on patient outcome in emergency situations.

Target Population:
The El Paso region is disproportionately challenged by diabetes, obesity, cardiovascular disease, and a large elderly population. Further, 25% of the population is below the federal poverty level and 28% are uninsured. Chronic diseases such as diabetes and cardiovascular disease are exacerbated by income and insurance status as many of the chronic conditions are more likely to be present or worse in low income populations.

Benefit to Medicaid/Indigent Patients:
Medicaid/indigent patients, along with the broader population of El Paso region, will benefit from faster deployment/response time, especially in the event of significant trauma or heart attack. The automated dispatch system enhances the present system, by decreasing response times with the use of an automated voice system while the dispatcher communicates with the caller. The project will provide the community with a higher percentage of positive outcomes for those needing emergency care. The system will help in the analysis of response times and identifying areas with current health related challenges the El Paso region possesses.

Expected Benefit of Project:
Category 1 Milestones: Procure and implement automated dispatch system; monitor deployment trends; develop and implement quality benchmarks for triaging and response time; collect and report patient experience data; adjust staffing and response protocols, as needed
Category 3 Outcome Measures: Decreased response time with evidence of reduced complications due to earlier interventions; improved survivability rates

Project Description:
The City of El Paso is currently using a manual, analog 800 MHZ trunked dispatching radio system. At present time, the system requires 9 to 11 call takers to process phone calls. Information is electronically uploaded to the fire dispatcher with assistance from the Computer Aided Dispatch system (CAD). The dispatcher is then required to verify incident, recommend units, location availability of units and dispatch over a single talk group. The talk group is a single channel with two way information traffic. The talk group is used for dispatching units to incidents, communication between dispatch and units while en route to incidents, communication with units out of station not responding to incidents and mobile units. During multiple incidents and receiving 911 calls, dispatch experiences a back log of dispatches (stacked calls). This is due to having to communicate with each unit independently. These combined actions increase the extended time of dispatching emergency apparatus to an incident creating longer response times.

To improve County Public health, the City of El Paso Department of Public Health is proposing to enhance dispatch performance (Project 1.10 Enhance Performance Improvement and Reporting Capacity) and reporting to decrease dispatch times. This will ensure the public receives prompt Emergency Medical Care for the region. Once the dispatch system is installed and operational, an assessment will be completed to establish new baseline response times. These new response times will allow for improvements to be tracked and result in a positive patient outcome.

Goals and relationships to regional Goals
The goal of this project is improve prompt Emergency health care response to the El Paso area while providing accurate real time location data. This result of an automated dispatch system will decrease response times from the time the public calls 911 to arrival of an emergency vehicle to the scene. The reduction of time to the scene on an emergency will increase survivability rates as well quality of life for the region. Data will be obtained through the system to analyze and share information to meet and improve the quality of emergency care.

Project Goals:
- Conduct training requirements with the new system to 911 dispatchers and field emergency personnel.
- Introduce the automated system to the existing CAD system with software updates at the 911 dispatch center.
- Enhance communications through software upgrades to responding emergency vehicles and stations.
- Conduct research on response times with comparison to manual analog system.
- Analyze emergency call data and health information data by catchment area of emergency response station to differentiate staff skill sets/training requirements by needs of service population
- Show reduction in response times from time of call to arrival on the scene.
- Show increased survivability rates and quality of life issues after an emergency event.

This project meets the following regional goals:
The Automated Dispatch project will enhance regional capacity to respond to health related medical emergencies.

- Provide the full continuum of healthcare services, from wellness to preventative care to disease management, to emergent, to palliative and hospice care.

Challenges :
Challenges that may occur will happen during the transition phase between the two systems. The areas include training with the 911 system and the timing of installation changes in software from the current system to the automated system. The changes will occur at the dispatch center, vehicles and stations and can possibly cause disruption on current 911 dispatching. Challenges in the future will be to insure a quicker response time with education to the community on the recognition of a medical emergency. This challenge can be crucial with the change in the community in regards to an increasing elderly category of "baby boomers".
Addressing the above challenges will require strategic rollout of the automated dispatch system; trial testing of the system to identify/resolve technical and operational issues; and intensive training of 911 dispatch and field emergency medical services staff. In addition to troubleshooting and fixing equipment/software and operational issues (internal preparation), effective implementation of the automated dispatch system will necessitate community education on advantages of automated v. manual dispatch in response time, triaging, and appropriate field intervention (external preparation). To realize the full potential of the systemic change in dispatch process, the broader community will need to be trained in basic triaging skills to properly assess status of medical condition and communicate accurate/complete information to dispatch staff. Fire department personnel will prepare appropriate/tailored training/education materials and conduct training activities for select populations, e.g., senior centers, neighborhood organizations.

5 Year Expected Outcome for Provider and Patients:
Within the 5 year work period the region will see a commitment to improved response time; enhanced emergency medical care system; improved survival rates and a quality of life after release from an area hospital. The information gathered will determine trends within the region and specific areas that will help responders to insure the best care possible. The collected data will also allow better training in the field directly related to regional health issues that will have been diagnosed. The statistical information will help in continuing education to the region on the importance of recognizing true emergencies and health issues.

Starting Point Baseline:
Current existing dispatch average time (Dispatch call handling 3:27 min., Turn out time 1:42min., 1st unit arrival travel to scene 7:04min. and a total time response 13:24min.)

Rationale:

There are many areas of concern in the public health community, Cardiac arrest being one of them. In medical emergencies, sudden cardiac arrest patients may become irreversible if ALS intervention is not implemented early. According to Ludwig (2004), The American Heart Association's scientific position, is that brain death and permanent death start to occur in 4-6 minutes after someone experiences cardiac arrest. The window of opportunity for the chance of survival with no neurological deficits to the patient decreases the later care arrives.

The El Paso region has many health related challenges: diabetes, obesity due to poor nutrition, decreased daily exercise and a large elderly population that significantly increases cardiac emergencies in the community. Most 911 calls pertaining to patients with chest pain, without prompt care, can lead to a cardiac arrest situation. These patients require a rapid dispatch and transport to the hospital to restore blood and oxygen to the heart. Other medical emergencies where time is an issue is those with signs and symptoms of an acute stroke, respiratory disease and trauma patients that require a Level I trauma hospital.

Project components (1.10.2)

a) Provide training and education to clinical and administrative staff on process 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.
c) Design data collection systems to collect real-time data that is used to drive continuous quality improvement.

Unique Community need identification numbers the project addresses
CN.1 Primary Care
CN.2 Secondary/Specialty Care
CN.6 Other community need as identified by the performing provider

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

The automated dispatch system enhances the present system, by decreasing response times with the use of an automated voice system while the dispatcher communicates with the caller. The present system requires the dispatcher to stop communicating with the caller in order to dispatch the call to the station. With the use of the new system, the dispatcher has the ability to handle a higher call volume without added staff and experiences a reduction in stacking of calls. The project will provide the community with a higher percentage of positive outcomes for those needing emergency care. The system will help in the analysis of response times and identifying areas with current health related challenges the El Paso region possesses.

Related Category 3 Outcome Measure(s):
Outcome Domains ((OD-9): Right Care, Right Setting
Improvement Targets IT 9.4 (DY4-5): Other Outcome Improvement Target

Reason/Rationale for selecting the outcomes measures:
Selecting outcome improvement targets allows the department the flexibility of focusing on what is important for the community. The outcome of the proposed DSRIP is to reduce response times to the region for emergency response care. Specific targets will be established as an assessment is performed after the system is fully operational and all locations have been upgraded.

Relationship to Other Projects:

The El Paso Fire Department complements other Health department DSRIP submissions: El Paso Community Health Atlas (065086301.1.2), which seeks to develop a comprehensive biomarker database which can be analyzed by zip code or other geo, demographic, or health-related criteria for research and targeted interventions to address health disparities in the border region and the Border Public Health Interest Group (065086301.1.1) which seeks to collect and analyze REAL data for identification and reduction of disparities related to race, ethnicity and language. The El Paso Fire Department can supplement data acquired through the biomarker program by dissemination of medical disposition cluster analysis through the TRIPTIX reporting system. This system evaluates trends in response, monitors types of medical issues and partners with bio watch to help identify biohazards.

Relationship to Other Performing Providers' Projects in the RHP

The El Paso Fire Department also complements other DSRIP initiatives in Region 15 including:

- UMC: Enhance Performance Improvement and Reporting Capacity at UMC Neighborhood Health Centers
- UMC: Chronic Care Model for Neighborhood Health Centers
- Texas Tech: Disease Management Registry
- Tenet: Enhance Interpretation Services and Culturally Competent Care
- HCA: Chronic Disease Management Registry

Plan for Learning Collaborative:

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the delivery system for the low-income Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share its experiences and challenges in implementing its DSRIP projects, but also recognizes the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare and indigent population.

Project Valuation:

The value to the community of the Automated Emergency Dispatch System DSRIP project over the course of the funding period is $7,445,616. Of that amount $5,793,499 has been allocated for Category 1 Infrastructure Development. The valuation takes into account a complete upgrade of

the dispatch system that includes: a new voice automated system, CAD interface, software and hardware systems, audio licenses, training and configuration, station dispatch equipment, and warranty. The proposed project also takes into account the efficiencies of response times and the possible reduction of health costs in the region. While the reduction in costs for healthcare is conservative, only a fully operational automated dispatch system in the region will be able to determine the true savings in health care cost.

065086301.1.4	1.10.2	1.10.2 (A-C))	PROJECT TITLE: AUTOMATED EMERGENCY DISPATCH SYSTEM	
Performing Provider Name: City of El Paso Department of Public Health				TPI: 065086301
Related Category 3 Outcome Measures	**065086301.3.4**	IT-9.4	**OD-9 Right Care, Right Setting** 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)
Process Milestone P-5 Enhance or expand the organizational infrastructure and resources to store, analyze, and share the patient experience data and/ or quality measures data, as well as utilize them for quality improvement **Process Metric** P-5.1 Increased collection of patient experience and/ or quality measures data Goal: Implement automated dispatch system. Monitor unit deployment trends, e.g., triaging of calls, response times. Report findings and adjust staffing and response protocols, as needed. Data Source: Performance monitoring/tracking data system Expected Patient Benefit: Improved triaging of calls and average response time; earlier intervention; increased opportunity for family education by EMS staff; referral to other health resources	**Process Milestone** P-5 Enhance or expand the organizational infrastructure and resources to store, analyze, and share the patient experience data and/ or quality measures data, as well as utilize them for quality improvement **Process Metric** P-5.1 Increased collection of patient experience and/ or quality measures data Goal: Implement automated dispatch system. Monitor unit deployment trends, e.g., triaging of calls, response times. Report findings and adjust staffing and response protocols, as needed. Data Source: Performance monitoring/tracking data system Expected Patient Benefit: Improved triaging of calls and average response time; earlier intervention; increased opportunity for family education by EMS staff; referral to other health resources	**Improvement Milestone** I-9 Demonstrated improvement in 2 selected quality measures **Improvement Metric** I-9.1 Improvement in selected quality measures Goal: Develop/implement quality improvement data system with benchmarks for appropriate triaging of emergent calls and response time expectations**.** Collect and report patient experience data; adjust operations, accordingly Data Source: Performance monitoring/tracking data system; evidence of evaluative/reactive response to patient experience data system Expected Patient Benefit: Improved triaging of calls and average response time; earlier intervention; increased opportunity for family education by EMS staff; referral to other health resources	**Improvement Milestone** I-9 Demonstrated improvement in 2 selected quality measures **Improvement Metric** I-9.1 Improvement in selected quality measures Goal: Develop/implement quality improvement data system with benchmarks for appropriate triaging of emergent calls and response time expectations**.** Collect and report patient experience data; adjust operations, accordingly Data Source: Performance monitoring/tracking data system; evidence of evaluative/reactive response to patient experience data system Expected Patient Benefit: Improved triaging of calls and average response time; earlier intervention; increased opportunity for family education by EMS staff; referral to other health resources

065086301.1.4	1.10.2	1.10.2 (A-C))	PROJECT TITLE: AUTOMATED EMERGENCY DISPATCH SYSTEM	
Performing Provider Name: City of El Paso Department of Public Health				TPI: 065086301
Related Category 3 Outcome Measures	**065086301.3.4**	IT-9.4	**OD-9 Right Care, Right Setting** 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)
Estimated incentive payment: $746,750 **Process Milestone** P-9 Participate in face-to-face learning at least twice per year with other providers and 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). Each participating provider should publically commit to improvements **Process Metric** P-9.2 Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative Estimated Incentive Payment:	Estimated incentive payment: $700,027 **Process Milestone** P-9 Participate in face-to-face learning at least twice per year with other providers and 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). Each participating provider should publically commit to improvements **Process Metric** P-9.2 Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative Estimated Incentive Payment:	Estimated Incentive Payment: $749,982 **Process Milestone** P-9 Participate in face-to-face learning at least twice per year with other providers and 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). Each participating provider should publically commit to improvements **Process Metric** P-9.2 Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative Estimated Incentive Payment:	Estimated Incentive Payment: $699,992 **Process Milestone** P-9 Participate in face-to-face learning at least twice per year with other providers and 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). Each participating provider should publically commit to improvements **Process Metric** P-9.2 Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative Estimated Incentive Payment:

065086301.1.4	1.10.2	1.10.2 (A-C))	PROJECT TITLE: AUTOMATED EMERGENCY DISPATCH SYSTEM	
Performing Provider Name: City of El Paso Department of Public Health				TPI: 065086301
Related Category 3 Outcome Measures	**065086301.3.4**	IT-9.4	**OD-9 Right Care, Right Setting** 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)**
$746,750	$700,026		$749,981	$699,991
Year 2 Estimated Milestone Bundle Amount: $1,493,500	Year 3 Estimated Milestone Bundle Amount: $1,400,053		Year 4 Estimated Milestone Bundle Amount: $1,499,963	Year 5 Estimated Milestone Bundle Amount: $1,399,983
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $5,793,499				

95771

City of El Paso Department of Public Health
Pass 2 DSRIP Project: Regional Data Validation of Health Information Exchange

Identifying Project and Provider Information:

Title of Project: Regional Data Validation of Health Information Exchange for El Paso
RHP Project Identification #: 065086301.1.5 Pass 2
Project Option: 1.5.2 Implement data sharing agreements to aid in health disparity evaluation
Performing Provider Name: City of El Paso Department of Public Health/065086301

Summary Information:

A. Provider Description:

The Performing Provider for this project is the City of El Paso Department of Public Health. The Department of Public Health has 270 employees and an annual budget of $19M. The department provides food protection, epidemiology, preparedness, laboratory, population-based health planning, WIC, and 211 Call Center services. In addition, the department is a clinical provider for dental health, immunizations, tuberculosis control, and STDs diagnosis and treatment. Primary catchment area for the Public Health Department is the City of El Paso. The Department also provides services for other municipalities within El Paso County and the unincorporated area through interlocal agreements. Finally, there are select grant programs, e.g., WIC, where the terms of the grant require the Department to serve Hudspeth County. Total population for the service region is approximately 820,000.

B. Intervention:

The City of El Paso Department of Public Health is proposing a four year developmental effort to expand an existing health information exchange (HIE). The El Paso region HIE is a collaborative initiative of area hospitals, public health, private practices, Medical Society, and a local health foundation. Purpose of the initiative is to expand participation in HIE to improve communication of health information and, ultimately, health status of covered lives.

C. Description of Need:

The pathway to improving care, reducing medical errors, lowering medical costs and achieving meaningful use of patient information is facilitated though health information exchange. In the El Paso region although many large organizations have electronic health records, others don't, making the exchange of information only possible with a fraction of the health care community. In order to adequately promote exchange among more providers and provide needed information for regional planning a means to collect and access data is needed.

D. Target Population:

Individuals living in El Paso region and acute and non-acute health care providers in the community.

E. Benefit to Medicaid/Indigent Patients:

Having just-in-time access to health information has been shown to improve the quality of care delivered; improve workflow; enhance patient satisfaction; eliminate the need for unnecessary or duplicative testing and improve patient safety. In addition, having the capability to look at trends enables decision makers to develop strategies related to educational outreach to particular populations; facilitate mechanisms for access to appropriate levels of care, thereby allocating resources appropriately to improve outcomes (financial, clinical, quality, and patient and provider satisfaction). Given that low income populations are disproportionately represented in many chronic conditions, e.g., diabetes, an HIE would afford the community of providers opportunities for better coordination of care, monitoring of health status, and design of effective disease control/prevention interventions. This project proposes to improve compliance rates among Medicaid/uninsured adults for breast cancer screening, colorectal cancer screening, and pneumonia vaccination.

F. Expected Benefit of Project:

Category 1 Milestones: Continue the developmental work of the Health Information Exchange initiative currently underway in El Paso through the Paso del Norte Health Foundation; identify early adopters; provide deliverables based on information needs of enrolled providers; cull data elements to avert collection of unused, non-applicable data; streamline health information exchange enrollment processes/data access requirements to facilitate expansion of provider base.

Category 3 Outcome Measures: Interface HIE with other data repository/analysis initiatives, e.g., Community Health Atlas, to provide more complete dataset on health system users/non-users. Analyze databases for REAL data relative to chronic disease diagnosis, access to care, treatment, prognosis, and outcome. Develop targeted interventions to address disparities by population and location. Specifically, the HIE initiative will promote/assure use of preventive health services in the areas of Breast Cancer Screening (IT 12.1), Colorectal Cancer Screening (IT 12.3) and Pneumonia Vaccination of Older Adults (IT 12.4).

Project Description:

The aim of this project is to expand collection and integration of regionally relevant healthcare data for border care not presently gather by the Texas Health Information Exchange. The Exchange collates data from multiple health care organizations into a centralized repository which allows for query of information for better management of patient care as well as the exchange “push” of data among health care providers through “Direct Protocol”. This project is designed to gather and integrate patient centered data for regional comparative effectiveness research in define populations living in our region.

Health Information Exchanges (HIEs) are designed to exchange patient health information across providers. The belief of employing a means to communicate amongst providers electronically as well as query information is believed to result in avoidable adverse drug interactions, fewer repeated tests, hospital readmissions and treatment episodes.

Health Information Exchanges are evolving to include more types of data from various resources including acute and non-acute settings, payer data and more. This diagram provides insight into how can be used to not only improve individual patient health but also in a broader context to improve population health.

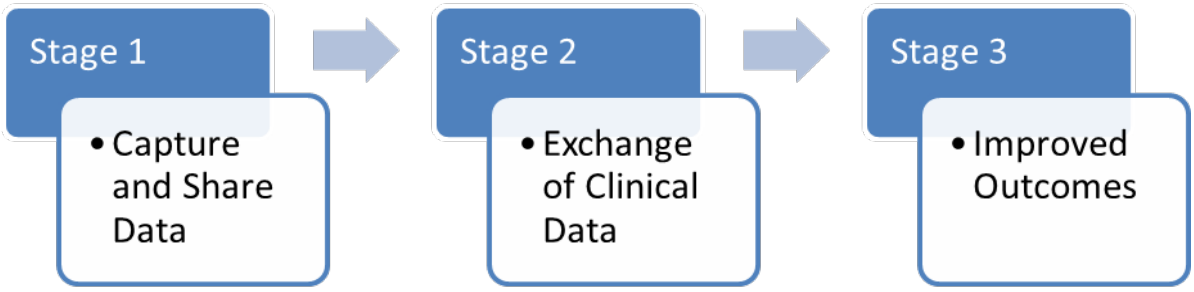
The main barriers preventing this exchange of information are related to both the adoption of electronic medical records, electronic prescribing, and the ability to facilitate interoperability among disparate systems. The first barrier adoption of electronic medical records has been greatly overcome through Medicare E.H.R. Incentive payments to eligible hospitals and professionals including physicians who demonstrate meaningful use of certified Electronic Health Record technology which began in 2011. Although the incentive does not provide for the full cost of implementing an electronic medical record it does provide assistance with this endeavor. The Meaningful Use incentive is constructed to continually expand from data collection, data query that is internal in the organization, to communicate it amongst providers external and internal to the organization, as well as the patient. In addition, these data are integrated and analyzed at the provider level and not at a community level therefore lacking a step of validation. The intent of this project is therefore to close that gap by integrating and validating regional data with community-gathered information. This last step of incorporating community-gathered information is critical to capturing patient satisfaction information within the continuum of care including cost and quality assessment. To avert provider bias, this must be done separate from providers gathering and analyzing their operational data. The health Information comparative repository will be feed back to the HIE participants in a way that is responsive to patient/ community centered care and adds a check and balance step to the HIE analytic process. Paso Del Norte Foundation is developing the HIE for El Paso and surrounding communities. The federal funding ends in August 2013. There is no overlap with the initiatives for this project with the current federal funding for HIE.

A. Overview of Stage 1 to 3-Movement

MU Stage 1- Automate inter-organizational processes and capture information electronically

MU Stage 2- Connect the community and share data inter-organizationally. Connect the person, integrate and create executable knowledge

MU Stage 3-build learning modules of health preservation and treatment



Goals and Relationship to Regional Goals

The HIE project will provide the ability to query a broader base of data by enabling the exchange and centralized collection of health information. This aligns with regional goals of:

- Improving the quality of care in El Paso County through better communication amongst health care providers/organizations.
- Enhancing disease prevention and promotion of early detection screening
- Enrich regional health planning

Project Goals:

The overarching goal of the project is to expand the existing health information exchange (HIE) by adding a Centralized Data Repository to facilitate information exchange among a broader group of health care providers including EMS. Additionally, the project can be tied with the El Paso Community Health Atlas Project in order to allow public health mapping to improve the efficiency and quality of public health surveillance and regional planning.

Challenges:

The challenges associated with creating a centralized data warehouse range from collaboration amongst parties; clear agreement on data to be used; how data will be transmitted; security of data transmission; integrity of data; how data will be used; who will have access to data and legal concerns(HIPAA, State laws, etc.). These challenges can be overcome by having a having advisory and working group of experts involved in the design of the model that facilitates data exchanges without additional work to participants in a secure platform. Patient privacy concerns: HITECH's expanded civil penalties and enforcement need to be reviewed with participants and how data will be protected. State statutes should also be reviewed around communicable disease information and how this is addressed in the project.

There is also an overriding challenge that all providers do not have access to electronic health record in which to access or push information to a centralized repository thus a solution that enables access to these practitioners is critical and provides the basis of why middleware is key to the success of the project which will enable data to be collected from various formats and allow access via the web to providers which would not otherwise have access to critical information.

Five (5) Year Expected Outcome for Providers and Patients:

Over a five year work period the HIE Centralized Data Repository will demonstrate how the collection, analysis, and dissemination of health information can inform the community of decision makers (patients, providers, and others); engage them in design/implementation of effective interventions; and assist them in evaluating process/outcome.

Starting Point Baseline:

This is a new initiative of the city of El Paso Department of Public Health; hence, baseline is zero (0). However, work on the HIE is already underway through a community of providers initiative. Paso del Norte Health Foundation which promotes wellness and prevents disease in the region through leadership, research, and advocacy has been working with area hospitals, private physicians, and the health department on development of an HIE. Currently, Paso del Norte Health Foundation has in operational status a Health Information Exchange which offers both a referral application and direct protocol services, allowing for HIPPA compliant exchange of clinical data between providers of care. To date, nine practice sites are fully implemented. Beginning 2013, PDN Foundation will begin building the required infrastructure to develop a community health record. The current working group will work with experts in research, public health, and information technology to develop an analytic capacity of the community health record for comparative analyses.

Rationale:

There is substantial evidence that informed investment in health information technology (IT) which allows the health care sector to transform from a largely paper-based system to an electronic or digital system can lead to improvements in health care quality and patient safety, and help avoid unnecessary spending. Increasingly, interest in information technology has focused on health information exchange (HIE) that facilitates the sharing of information, thereby allowing personal health information to securely follow the patient.

Currently, the exchange of data in health care is being supported by the "Meaningful Use" initiatives by both Medicare and Medicaid for hospitals and health practitioners. The first stage of the Hi-tech Iteration involves the capture and sharing of data electronically. Next is Stage 2 which is aimed at connecting the community and sharing data inter-organizationally. Further connecting the person, integrating data, and creating executable knowledge, Stage 3 and beyond intent is to build learning models of health preservation and treatment (improved outcomes) (Intiative, 2012).

Meaningful Use is also tightly tied to the Accountable Care Organizations as we better understand the population by mining data we can identify opportunities for improvement which can lead to better outcomes in a cost effective way and share in the savings and risk.

Currently there is not a process of check and balances or regionalization of data that catalyzes community decisions concerning care – that enables the community and patients a means to tailor care which is culturally appropriate and meets or surpasses standards of fairness in cost and

quality along the continuum of care, i.e., cost at the end of life, right to selection of medication and providers etc.

Project Components:

There are no specific project components to Project Option 1.5.2. However, the project option does require quality improvement/continual performance improvement activities including: (1) lessons learned; and (2) identifying opportunities for scaling and replication of successful interventions. The HIE project will build into its project continual performance improvement processes to address the requirements of this section.

Unique community need and identification number(s) the project addresses:

CN.6 Other Community Need as Identified by the Performing Provider

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

This project builds upon the work of the current community provider-based HIE initiative through the Paso del Norte Health Foundation by helping to assure that the collection/analysis of data for improved/more efficient delivery of provider services ALSO addresses the larger context of community health improvement especially where health disparities exist. The data repository of the HIE initiative will interface with the Community Health Atlas project to provide a more complete picture of health needs of the El Paso region. The inclusion of patient and community feedback in information gathering and reporting will improve accountability and utility of data for effective intervention design.

Related Category 3 Outcomes Measure(s):

Outcome Domain (OD-12): Primary Care and Primary Prevention
IT-12.1 Breast Cancer Screening (065086301.3.5)
IT-12.3 Colorectal Cancer Screening (065086301.3.6)
IT-12.4 Pneumonia Vaccination (065086301.3.7)

Reason/Rationale for selecting the outcomes measure(s):

There is currently no regional data repository for health information for exchange of patient information, policy or regionally planning and development. Improvement targets relative to HIE enrollment will be determined as HIE is marketed to area providers. Improvements from using the HIE as a component of the Health Atlas initiative will be determined as expectations are defined/refined and data interface issues are addressed. To demonstrate the value of the HIE and the interface to the Atlas, 500 Medicaid/uninsured adults who have not received preventive screenings and/or pneumonia vaccination will be identified and necessary services provided.

Relationship to Other Projects:

The El Paso Regional Data Validation of Health Information Exchange complements another health department DSRIP submission the Border Public Health Interest Group which seeks to analyze REAL data to describe regional/local health problems and develop appropriate policy and program interventions and the El Paso Community Health Atlas.

Relationship to Other Performing Providers Projects in the RHP:

The El Paso Regional Data Validation of Health Information Exchange complements other DSRIP initiative's in Region 15 including:

- HCA: Chronic Disease Management Registry
- Texas Tech: Disease Management Registry
  UMC: Chronic Care Model for Neighborhood Health Centers

Plan for Learning Collaborative:

The Anchor for Region 15 (UMC), performing providers, and IGT entities has held consistent monthly meetings throughout the development of the 1115 waiver projects. As noted by HHSC and CMS, meeting and discussing waiver project successes and challenges facilitates open communication and collaboration among participants. We plan on using various channels of communication moving forward including but not limited to: (1) conference calls; (2) online and physical meetings; (3) newsletters; and (4) conferences to provide a means to share ideas, experiences, and identify ways in which to continually improve programs and efforts. It is imperative that data projects come together and discuss what is being collected and how, as well as engaging with the larger group to ensure the project activities are known to them and that we are working together to ensure appropriate use of resources and provide communication and dissemination of information on project goals and timelines.

UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and breaking the larger group into Learning Collaboratives that meet on a more frequent basis to address specific DSRIP project areas, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which includes the regional projects listed by Performing Provider, contact information of each participant, as well as minutes, notes, slides and HHSC information. The Paso Del Norte/Health department project plans on having a web site which will provide the participants, anchor, and community a means to engage in the project. The site will have a calendar activities and conferences in which the project will participate, videotaped presentations, a Gantt chart on the tasks to be undertaken and timeline progress, as well as resources identified.

It is our plan to work together with other participant's to organize at a minimum an annual conference for the region, as well as gather annually with state wide entities to share experiences and challenges in implementing projects.

Project Valuation:

The proposed value (community benefit) of the Regional Data Validation of Health Information Exchange for El Paso is $489,675 over the DSRIP funding period (DY 2-5). Of this amount $431,961 has been allocated for the value of Category 1 Infrastructure Development. The valuation takes into account direct staffing for the HIE initiative (project director and support staff); HIE enrollment fees; software interface consultation/programming; back office functions (payables and receivables management, fiscal and program reporting, human resources); program management to troubleshoot scheduling/staffing/production issues; evaluative services for collection and analysis of activity and other performance data relative to DSRIP reporting requirements.

065086301.1.5 PASS 2	*1.5.2*	*1.5.2 (*	*PROJECT TITLE: Regional Data Validation of Health Information Exchange*
Performing Provider Name: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.5; 065086301.3.6; 065086301.3.7*	*IT 12.1 IT 12.3 IT 12.4*	*Breast Cancer Screening Colorectal Cancer Screening Pneumonia Vaccination*

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 P-4 Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Process Metric** P-4.1 Description of elements of the system Goal: Inventory data sources for interface with HIE database; identify opportunities for standardization of REAL data collection through HIE; develop/implement policies, as needed Data Source: Policies and procedures Estimated Incentive Payment: $48,9990 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of seminars, at least twice per year with other providers and	**Process Milestone** P-4 Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Process Metric** P-4.1 Description of elements of the system Goal: Continue data source inventory; identify opportunities for standardization of HIE REAL data collection; develop policies, as needed Data Source: Policies and procedures Estimated Incentive Payment: $53,809 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of seminars, at least	**Improvement Milestone** I-12 Implement intervention to make improvements in REAL data collection and use **Improvement Metric** I-12.1 Documentation of increased number of HIE unique patients with documented REAL data using innovative program option. Demonstrate improvement over prior reporting period (baseline for DY 2) Goal: interface HIE collected data with other data sources/systems; develop reporting formats; analyze and report health status data, inclusive of HIE, by zip code. Identify 250 Medicaid/uninsured adults in need of primary prevention services (breast cancer screening, colorectal screening, and/or pneumonia vaccination); provide preventive screenings/services	**Improvement Milestone** I-12 Implement intervention to make improvements in REAL data collection and use **Improvement Metric** I-12.1 Documentation of increased number of HIE unique patients with documented REAL data using innovative program option. Demonstrate improvement over prior reporting period (baseline for DY 2) Goal: Interface HIE collected data with other data sources/systems; refine reporting formats; develop tailored reports for healthcare providers, policy makers, and general public; report health status data. Identify an additional 250 Medicaid/uninsured adults in need of primary prevention services (breast cancer screening, colorectal screening, and/or pneumonia vaccination); provide preventive

065086301.1.5 PASS 2	*1.5.2*	*1.5.2 (*	*PROJECT TITLE: Regional Data Validation of Health Information Exchange*
Performing Provider Name: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.5; 065086301.3.6; 065086301.3.7*	*IT 12.1 IT 12.3 IT 12.4*	*Breast Cancer Screening Colorectal Cancer Screening Pneumonia Vaccination*

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 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). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $49,000	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). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative.	Data Source: Data analysis and reporting Estimated Incentive Payment: $57,559 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP P-8.2	screenings/services Estimated Incentive Payment: $55,613 **Process Milestone** P-8 Participate in face-to-face learning, i.e., meetings of 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 should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Process Metric** P-8.1 Participate in semi-annual face-to-face meetings organized by the RHP

065086301.1.5 PASS 2	***1.5.2***	***1.5.2 (***	***PROJECT TITLE:*** *Regional Data Validation of Health Information Exchange*	
Performing Provider Name: City of El Paso Department of Public Health				*TPI: 065086301*
Related Category 3 Outcome Measures:	*065086301.3.5; 065086301.3.6; 065086301.3.7*	*IT 12.1* *IT 12.3* *IT 12.4*	*Breast Cancer Screening* *Colorectal Cancer Screening* *Pneumonia Vaccination*	
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)**
	Estimated Incentive Payment: $53,809		Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $57,559	P-8.2 Implement the "raise the floor" improvement initiatives established at the semi-annual meeting Goal: Participate in face-to-face learning Data Source: Documentation of semi-annual face-to-face meetings; evidence of "raise the floor" initiative. Estimated Incentive Payment: $55,613
Year 2 Estimated Milestone Bundle Amount: $97,999	Year 3 Estimated Milestone Bundle Amount: $107,618		Year 4 Estimated Milestone Bundle Amount: $115,118	Year 5 Estimated Milestone Bundle Amount: $111,226
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $431,961				

Project Option 2.6.4 Implement other evidence-based project to implement evidence-based health promotion programs in an innovative manner not described in the project options above: **THE SALVATION ARMY, REDSHIELD HEALTH—A HOLISTIC WELLNESS PROGRAM FOR THE HOMELESS**

Unique Project ID: 138951211.2.1
Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

Intervention(s): This is a new program. This project will provide nursing care and an in-house wellness program to indigent patients who reside at the Salvation Army. Currently, residents of the Salvation Army do not have access to primary care services, and come to the UMC ED for their healthcare needs. Diabetes treatment will be a large portion of care provided for this target population; however, the residents will receive any ongoing medical care they need via RN's who are located in the Salvation Army. This project will develop a program for clients to gain control of their healthcare through disease management, medication compliance, appropriate diet and nutrition, and lifestyle changes.

Need for the project: Clients will receive nursing care in the shelter to better address ongoing maintenance of chronic conditions and to treat urgent conditions as they arise. This project will greatly reduce return emergency room visits while also reducing the inpatient days for this population, thereby reducing cost. Clients will also receive classes in nutrition, fitness and health management.

Target population: The Salvation Army serves approximately 350 homeless families with children (over 1,000 unique individuals) annually. The target population will be those residents with diabetes, hepatitis C, cirrhosis/liver disorders, hypertension and obesity or those with nutritional, fitness or health management deficits. This project will implement, document, and test an evidence-based strategy to reach these clients through approximately 6820 interventions over the term of the Waiver. This will be accomplished through the bi-weekly meetings with The Salvation Army and VNA to develop project. DY3 will focus on execution of the diffusion strategy by testing, spreading and sustaining the best practices and lessons learned during DY2. We will continue the bi-weekly meetings to collaborate learning and sharing around shared or

similar projects. Assessments of clients during this period will allow us to further refine our processes and meet the goals of health promotion and fitness of the population, thereby reducing the clients need for more intensive healthcare. The expectation is to reach 50 % of the Salvation Army residents during DY3. Interventions may include health assessment by RN, fitness assessment and training by fitness coach, nutrition assessment and training by nutritionist and healthier meals provided by addition of equipment and resources. This would give each unique individual the opportunity of four or more interventions (meals x 3, fitness training, nutritional training, health assessment) reaching 2000 plus interventions during DY3. Additional resources may need to be added to increase the target population reached in DY4, with a goal of 15 % increase in interventions (2300 interventions) reached in DY3. The goal for DY5 will be a 10% increase over DY4, or approximately 2530 interventions.

Category 1 or 2 expected client benefits: This project seeks to increase the number of clients reached from 2000 interventions in DY3 to 2300 in DY4 and 2530 interventions in DY5, as evidenced by screenings, education and outreach

Category 3: IT-11.6 Addressing Health Disparities in the Homeless Population. The current number of residents with chronic conditions is unknown at this time since this is a new program. Baseline data will be established in DY2 and we will improve the percentages of target population reached by 15% in DY 5 over the previous years. Our goal is to reduce PPR 30 day readmissions for chronic conditions of residents of the Salvation Army and eliminate unnecessary ER visits for the Salvation Army patients enrolled in the program by DY5.

Project Description:

Under this project, UMC will contract with Visiting Nurse Association of El Paso (VNA) to provide primary and preventive healthcare to residents of the Salvation Army shelter.

Under this project, UMC will contract with VNA to develop and implement a nursing program in order to provide primary and preventive healthcare to residents of the Salvation Army shelter in El Paso. The population to be served by this project is one which generally encounters difficulty accessing healthcare, including preventive services, and often does not experience proper coordination of care. The nursing program will address these areas.

The nursing program will also deliver education and support to empower this client population to gain control of their healthcare through disease management, medication compliance, appropriate diet and nutrition, and lifestyle changes. VNA will provide nursing and support services for the Salvation Army's residents in order to offer them a more appropriate alternative to using the UMC or other hospital EDs for their primary care or for other non-emergent care needs.

The Shelter will provide the physical space for this project, and VNA will provide nursing and support staff to monitor the chronic health conditions of those residing at the shelter. VNA will also conduct surveillance for communicable disease and similar problems that can be common in shelters. VNA's infection control nurse is experienced in the prevention and control of infections

in the home setting and will bring this knowledge to this new nursing program for application in shelter settings. Residents will have access to nursing services three days a week, and service schedules will be adjusted as necessary to meet the varying needs of the patient population.

Annually, this bilingual, culturally sensitive program will serve approximately 350 homeless families with children (over 1,000 unique individuals) by educating the population about preventative healthcare and wellness (including education on nutrition, fitness, counseling, and health management—including management of chronic diseases). The nursing program will directly provide for a nutritionist, a chef, kitchen equipment, supplemental nutritious foods including fresh produce, a wellness counselor, fitness resources, and prescription drug vouchers.

Goals and Relationship to Regional Goals:

Project Goals: This project will implement innovative evidence-based strategies in disease prevention areas. The project aims to improve the health of the local homeless population, increase health awareness and knowledge, reduce the use of area emergency rooms, and implement the principles of preventative healthcare to the homeless population. UMC intends that the project will reduce the number of patients who are admitted to the hospital as a result of difficulty managing chronic health conditions such as diabetes, obesity, and hypertension; the project will also reduce the use of emergency room visits by residents of the Salvation Army shelter by successfully managing their care on-site. Cost savings are also an expected benefit to the community, because this project will reduce the need for expensive inpatient or ED care.

This project meets the following regional goals: This project meets the regional goal of overcoming language, socio-economic, and monetary barriers to accessing healthcare resources in the region. The project will expand the provision of primary and preventive care to socio-economic groups at the Salvation Army shelter which previously did not have sufficient access to such care.

Challenges:

Challenges faced by this project include, but are not limited to: the transient nature of the population to be served by the nursing program; high rates of diabetes and related issues among this population; and cultural biases related to dietary and fitness habits. Many of those living in shelters have not only been displaced from their homes but also, in many cases, from their usual access to care. Coordination of care for a transient population is always difficult, and is only more difficult in light of the low health literacy of this population. Housing instability often detracts from regular medical attention, and a lack of consistent care aggravates health conditions, making health crisis episodes more dangerous and much more costly. These clients will be offered health assessment by nurses, healthier meals by placement of chef, kitchen equipment, funds for improving food served, availability of a nutritionist, availability of a fitness coach, and a program for prescription medications. All of these interventions can lead to a healthier lifestyle, which in return reduces visits to the hospital, therefore earlier intervention and less cost to the healthcare system.

5-Year Expected Outcome for Provider and Patients:

UMC expects that the provision of these services through a nursing program at the Salvation Army shelter will result in lower BMI, weight, and blood pressure rates for the target population. More generally, UMC expects that the target population will experience healthier lifestyles, and the community will experience reduced healthcare costs.

Starting Point/Baseline:

Services at the Salvation Army shelter begin with a comprehensive assessment by a nurse which includes a frequency-of-visits assessment to monitor the patient's condition and progress. This assessment also includes, at a minimum: development of a Risk Profile; measurement of vitals; physical assessment and assessment of ongoing healthcare needs; nutrition, glucose, and oxygen saturation monitoring; and evaluation of patient knowledge of the applicable disease as related to education and self-management goals. This assessment will serve as starting baseline data for this project.

Rationale:

Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. It can help manage and improve the health status of a defined patient population over the entire course of a disease.

By concentrating on the causes of chronic disease, the community moves from a focus on sickness and disease to one based on wellness and prevention. The National Prevention Council Strategy for Disease Prevention focuses on four areas: building healthy and safe community environments, expanding quality preventive services in clinical and community settings, helping people make healthy choices, and eliminating health disparities. To achieve these aims, the strategy identifies seven evidence-based recommendations that are likely to reduce the leading causes of preventable death and major illness, including tobacco-free living, drug- and excessive alcohol-use prevention, healthy eating, active living, injury and violence-free living, reproductive and sexual health, and mental and emotional well-being.

People experiencing homelessness are more likely to access the most costly forms of healthcare services. According to a report in the New England Journal of Medicine, homeless people spent an average of four days longer per hospital visit than comparable non-homeless people. This extra cost—approximately $2,414 per hospitalization—is attributable to homelessness. Offering healthcare services in the shelter will prove to be a valuable tool in reducing costs and improving the health outcomes of this population. VNA nurses will provide preventive screening, monitoring, and non-emergent care, supported by three medical directors which will be critical for the needs of this population. The provision of nursing services on-site will prevent individuals from experiencing acute illness and flooding the ED for their primary care needs, which is a growing trend. These services offer a continuum of care throughout the year, improving on preventive measures and education. The Salvation Army estimates that the

residents at the Salvation Army El Paso shelter average 15 to 20 emergency room visits each month. Of these emergency room visits, approximately 10% are admitted to the hospital for at least one night.

Project Components:

The implementation of this project at UMC El Paso will accomplish the following core project component:

a) 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.

- UMC will conduct quality improvement activities as part of the nursing program established under this project.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

This project will significantly enhance the primary and preventive care services available to transient and homeless patients in the El Paso community. Through their collaboration, UMC, VNA, and the Salvation Army will make it possible for this patient population to receive the sensitive and appropriate care which it needs and which it was previously unable to obtain.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations

IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT-3.1 All-cause 30-day readmission rate, for target patient population discharged to Salvation Army shelter

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the improvement in all-cause readmission rates for patients discharged to the Salvation Army shelter. Because the purpose of the project is

ultimately to improve the delivery of care in the setting where it is most appropriate, UMC believes this outcome measure will accurately track whether or not the project has been successful in its primary goal, from the perspective of the patients to whom the services are provided.

Relationship to other Projects: UMC plans to cooperate with VNA in implementing a similar program at the Rescue Mission, another homeless shelter in El Paso (138951211.2.2).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary or preventive care in the community for those patients who currently experience financial, geographic, or other barriers to accessing the care they need.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the costs and health complications that can be avoided with respect to the transient and homeless patient population when that population receives the right care in the right setting, rather than being forced to utilize the Emergency Department as its primary healthcare resource. This project will significantly address

the needs of the El Paso community by providing transient and homeless patients with essential primary and preventive care which is currently unavailable to them.

138951211.2.1	***2.6.4***	2.6.4	***THE SALVATION ARMY, REDSHIELD HEALTH***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations	***IT-11.5***	138951211.3.9	***Addressing Healthcare Disparities in Minority Populations (IT-3.1 All Cause 30 day Readmission Rate for Salvation Army Patients)***	
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, document, and test an evidence-based innovative project for targeted population. Metric 1 [P-3.1]: Document implementation strategy and testing outcomes. Baseline/Goal: Documentation and implementation of project strategy. Data Source: Performing Provider contract or other documentation in the OASIS and a homeless management information system. Milestone 1 Estimated Incentive Payment: $1,103,136 **Milestone 2** [CQI 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 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.	**Milestone 3** [P-4]: Execution of a learning and diffusion strategy for testing, spread, and sustainability of best practices and lessons learned. Metric 1 [P-4.1]: Document learning and diffusion strategic plan. Baseline/Goal: Documentation of plan. Target population—50 % of the 1000 clients—500 clients x 4 interventions (meals x 3, fitness training, nutritional training, health assessment) = 2000 plus interventions Data Source: Performing Provider contract or other documentation of implementation in the OASIS and a homeless management information system. Milestone 3 Estimated Incentive Payment: $1,203,462 **Milestone 4** [CQI P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and		**Milestone 5** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached by 15% over baseline of 2000 plus interventions—2300 interventions. Numerator: Number of individuals in target population reached by innovative project. Denominator: Number of individuals in target population—500 clients 2000 plus interventions Data Source: Documentation of target population reached by the innovative project. Hospital Discharges to Salvation Army; VNA/Salvation Army Documentation of individuals in program Milestone 5 Estimated Incentive Payment: $2,413,921	**Milestone 6** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached by 10%. Numerator: Number of individuals in target population reached by innovative project. Denominator: Number of individuals in target population—2300 Interventions. 10% increase over DY4—2530 interventions. Data Source: Documentation of target population reached by the innovative project. Milestone 6 Estimated Incentive Payment: $1,994,108

138951211.2.1	***2.6.4***	2.6.4	***THE SALVATION ARMY, REDSHIELD HEALTH***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations	***IT-11.5***	138951211.3.9	***Addressing Healthcare Disparities in Minority Populations (IT-3.1 All Cause 30 day Readmission Rate for Salvation Army Patients)***	
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: 2/month 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. Milestone 2 Estimated Incentive Payment: $1,103,136	the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: 2/month 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. Milestone 4 Estimated Incentive Payment: $1,203,462			
Year 2 Estimated Milestone Bundle Amount: $2,206,272	Year 3 Estimated Milestone Bundle Amount: $2,406,924		Year 4 Estimated Milestone Bundle Amount: $2,413,921	Year 5 Estimated Milestone Bundle Amount: $1,994,108
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,021,225				

93650

Project Option 2.7.6: Implement innovative evidence-based strategies to reduce, prevent and manage chronic diseases (including but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders, and hypertension), in children and adults.
Rescue Mission / VNA Shelter Program for the Homeless

Unique Project ID: 138951211.2.2
Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

Intervention(s): This is a new program. This project will provide nursing care to indigent patients who reside in the Rescue Mission. Diabetes treatment will be a large portion of care provided for this target population; however, the residents will receive any ongoing medical care they need via RN's who are located in the Rescue Mission. Clients will receive nursing care in the shelter to better address ongoing maintenance of chronic conditions and to treat urgent conditions as they arise. This project will develop innovative strategies to reduce, prevent and manage chronic diseases in children and adults.

Need for the project: UMC estimates that 280 unnecessary ambulance transports from the Rescue Mission to the ER occur each year. Currently, residents of the Rescue Mission do not have access to primary care services, and come to the UMC ED for their healthcare needs. This project will greatly reduce return emergency room visits while also reducing the inpatient days for this population, thereby reducing cost.

Target population: The target population is patients enrolled in the new nursing program at the Rescue Mission, clients with diabetes, hepatitis C, cirrhosis/liver disorders, hypertension and obesity. This clientele frequents the UMC ED for any type healthcare need. This project will serve approximately 1,800 patients and the number of visits per patient could multiply that number exponentially for total impact of the program. This will comprise of all clients residing at the Rescue Mission. The Rescue Mission clients will be assessed by implementing, documenting, and testing an evidence-based strategy. This will be accomplished through the bi-weekly meetings with The Rescue Mission and VNA to develop project. The target population for DY2 will be 300 unique clients to begin execution of the diffusion strategy by testing, spreading and sustaining the best practices and lessons learned. We will continue the bi-weekly

meetings to collaborate learning and sharing around shared or similar projects. Assessments of clients during this period will allow us to further refine our processes and meet the goals of health promotion and fitness of the population, thereby reducing the clients need for more intensive healthcare. The goal for DY3 is to provide 400 patient interventions; DY4 to provide 500 patient interventions; and DY5 to provide 600 patient interventions. Additional resources may need to be added to increase the target population reached through the term of the waiver. These clients may require multiple interventions, such as assessment, education, nutrition awareness, and fitness and medication compliance. The numbers indicate unique clients, and not total visits.

Category 1 or 2 expected patient benefits: This project seeks to begin the nursing program at the Rescue Mission, and to increase the number of clients reached by 100 additional patient interventions each year, as evidenced by screenings, education and outreach.

Category 3: IT-11.6 Our goal is to reduce the 30-day potentially preventable readmission rate from the Rescue Mission population 25% by DY5 for chronic conditions note in target population.

Project Description:

Under this project, UMC El Paso will enter into a contract to transition all Rescue Mission discharges into the VNA Nursing Shelter Program.

The Rescue Mission's Nursing Program will be designed to provide primary and preventive healthcare to residents living at the Rescue Mission, a homeless shelter in El Paso. This is a population that generally encounters difficulty accessing healthcare, preventive services, and especially coordination of care. This program also delivers education and support to empower them to gain control of their lives through disease management, medication compliance, appropriate diet and nutrition, and lifestyle changes. VNA will provide the nursing and support services for the Rescue Mission's residents to prevent them from using the County Hospital or other EDs for their primary care or for non-emergent care needs. The Shelter will provide the space and VNA will provide the nursing and support staff where we will be able to monitor the chronic health conditions of those residing at the shelter. Also patients identified as at-risk for chronic diseases need interventions to change behavior and lifestyle choices so the development of chronic conditions can be decreased or prevented. VNA will also conduct surveillance for communicable disease and problems common in shelters. Our infection control nurse is experienced in the prevention, education and control of infections in the home setting and will bring this knowledge to this program for application in shelter settings. Residents will have access to nursing services 5 days a week and adjusted as necessary to meet the needs of the resident population.

Goals and Relationship to Regional Goals:

Project Goals: Implement innovative evidence-based strategies in disease prevention areas including the following: diabetes, obesity, prenatal care, and health screenings. Improve the health of the local homeless population, increase health awareness and knowledge, reduce the use of area emergency rooms, and implement the principles of preventative healthcare to the

homeless population. Reduce the number of patients who are admitted to the hospital as a result of difficulty managing chronic health conditions such as diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension. Reduce the use of emergency room visits by those in the homeless shelters by successfully managing their care on-site. Cost savings are also an expected benefit to the community by reducing the need for expensive inpatient care, unnecessary ambulance calls, or utilization of the ED as a first choice for care.

This project meets the following regional goals: This project meets the regional goals of overcoming language, socio-economic, and monetary barriers to accessing healthcare resources in the region, and of increasing patient satisfaction through delivery of high-quality, effective healthcare services. The project will expand the provision of primary and urgent care service to socio-economic groups which previously did not have access to such care by providing care which is appropriate to the needs of the homeless patient population.

Challenges:

Challenges faced by this project include but are not limited to a transient population, high rates of diabetes and related issues, and cultural biases related to dietary and fitness habits. Many living in shelters have not only been displaced from their homes but in many cases they have been displaced from their usual access to care. Coordination of care for a transient population is always difficult as well as health literacy. Housing instability often detracts from regular medical attention and the lack of consistent care aggravates their health conditions, making their episodes more dangerous and much more costly.

5-Year Expected Outcome for Provider and Patients:

UMC expects that the transition of UMC homeless patients to VNA Shelter Nursing Program at the Rescue Mission will greatly reduce or eliminate return emergency room visits while also reducing hospital inpatient days for this population. These patients will receive nursing care in the shelter to better address ongoing maintenance of chronic conditions and to treat urgent conditions as they arise. The cost of care and the cost burden on UMC will be reduced. This program will manage chronic conditions in a clinic setting and provide primary and urgent care services to the residents of the Rescue Mission.

Starting Point/Baseline:

Services at the Rescue Mission start with a comprehensive assessment by a nurse and include a frequency of visits to monitor the patient's condition and progress. Baseline data assessment includes at a minimum: A Risk Profile, vitals, physical assessment, assessment of ongoing healthcare needs, nutrition, glucose and oxygen saturation monitoring, and evaluate their knowledge of their disease for education and self-management goals. This assessment will serve as the starting baseline data for collection.

Rationale:

Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. It can help manage and improve the health status of a defined patient population over the entire course of a disease.[1]

The homeless experience higher rates of chronic disease than the general U.S. population. Most homeless have at least one chronic disease and with age, the risk of chronic disease rises. Although homeless shelters have the capacity to provide many necessary services, they do not have the formal capacity to provide medical care. Eliminating barriers to medical care for this population and through the provision of evidence-based interventions will reduce the chances for those who reside at shelters to have their conditions worsen. Ongoing patient-centered care monitoring allows interventions before exacerbations require and emergency room visit and/or hospitalization. Delivery Mechanisms: (note this list is not inclusive of all delivery mechanisms)

- Establish and use patient registry systems to enhance the provision of patient follow-up, screenings for related risk factors and to track patient improvement.
- Establish and implement clinical practice guidelines.
- Adopt the Chronic Care Model
- Develop a mapping process linking patients treated in the emergency rooms within RHP to improve the continuum of care and standardized procedures and outcome measures.
- Promote RHP health system supports such as reminders of care, development of clinical performance measures, and the use of case management services to increase patient's adherence to health care guidelines.
- Establish evidence-based disease and disability prevention programs for targeted populations to reduce their risk of disease, injury, and disability.

VNA nurses will provide preventive screening, monitoring, and non-emergent care, supported by three medical directors which will be critical for the needs of this population. The provision of nursing services on-site will prevent individuals from getting acutely ill or flooding the ED for their primary care needs which is a growing trend. These services offer a continuum of care throughout the year, improving on preventive measures and education. The Rescue Mission estimates that the residents at their shelter average 250-270 ambulance calls that may not result in transfer to ER. Also many emergency room visits occur each month by residents of the Rescue Mission. Of the emergency room visits, approximately 10% are admitted to the hospital for at least one night.

Project Components: 2.7.6 Other Project Option. Implement innovative evidence-based strategies to reduce, prevent and manage chronic diseases (including but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders, and hypertension), in children and adults.

The implementation of this project at UMC El Paso will accomplish the following core project components:

a) Development of innovative evidence-based project for targeted population.

        - UMC will contract with VNA to develop a program to manage chronic conditions in a clinic setting and provide primary and urgent care services to the residents of the Rescue Mission.

b) Transition UMC homeless patients from acute hospital care into the VNA Shelter Nursing Program at the Rescue Mission

    - UMC will transition homeless patients from UMC hospital care to the care of VNA of El Paso.

c) Implement a nursing program at Rescue Mission to provide a comprehensive assessment by a nurse and include a frequency of visits to monitor the patient's condition and progress.
        - UMC will contract with VNA to provide for nursing services that begin with a

    baseline data assessment includes at a minimum: A Risk Profile, vitals, physical assessment, assessment of ongoing healthcare needs, nutrition, glucose and oxygen saturation monitoring, and evaluate their knowledge of their disease for education and self-management goals. This assessment will serve as the starting baseline data for collection.

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.

    - UMC will conduct quality improvement activities as part of the VNA Nursing Shelter program established under this project.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care
- CN-3: Obesity and Diabetes
- CN-6: Other Projects

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

The provision of nursing services on-site will prevent individuals from getting acutely ill or flooding the ED for their primary care needs which is a growing trend. These services offer a continuum of care throughout the year, improving on preventive measures and education.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations; IT-11.5 (3.1 PPR All-cause 30 Day Readmissions for target homeless population discharged to the Rescue Mission with chronic conditions that include but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension)

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the improvement in all-cause readmission rates for patients discharged to the VNA Nursing Shelter program at the Rescue mission. Because the purpose of the project is ultimately to improve the delivery of care in the setting where it is most appropriate, UMC believes this outcome measure will accurately track whether or not the project has been successful in its primary goal, from the perspective of the patients to whom the services are provided.

Relationship to other Projects UMC plans to cooperate with VNA in implementing a similar program at the Salvation Army, another homeless shelter in El Paso (138951211.2.1; Discharge Navigation 138951211.3).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary or specialty care in the community for those patients who currently experience financial, geographic, or other barriers to accessing the care they need.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to

effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the costs and health complications that can be avoided when a patient population receives the right care in the right setting, rather than being forced to utilize the Emergency Department as its primary healthcare resource. This project will significantly address the needs of the El Paso community by providing uninsured and underinsured patients with hospice care which is currently unavailable to them. People experiencing homelessness are more likely to access the most costly health care services. According to a Texas hospital information source, Price Point, the average charge at UMC from October 2009 through September 2010 was $4,461 per day, with other hospitals in El Paso averaging $8,959. Offering healthcare services in the shelter will prove to be a valuable tool in reducing costs and improving the health outcomes of this population.

138951211.2.2	***2.7.6***	138951211.2.10.1	**Rescue Mission / VNA Shelter Program for the Homeless**
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): *OD-11 Addressing Health Disparities in Minority Populations*	IT-11.6 (PPR 30 Day Readmissions for target homeless population discharged to the Rescue Mission with chronic conditions that include but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension)	138951211.3.10	OD-11 Addressing Health Disparities in Minority Populations IT-11.6 (PPR 30 Day Readmissions for target homeless population discharged to the Rescue Mission with chronic conditions that include but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension)

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 evidence-based project for targeted population. Metric P-1.1: Document innovational strategy and plan. Data Source Performing Provider evidence of innovational plan **Baseline/Goal:** 300 patient interventions Milestone 1 Estimated Incentive Payment *(maximum amount):* $678,853 **Milestone 2** CQI P-5: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric P-5.1: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars, including	**Milestone 3** P-3: Execution of learning and diffusion strategy for testing, spread and sustainability. Metric P-3.1: Document learning and diffusion strategic plan Data Source Performing Provider contract or other documentation of implementation in OASIS or Homeless Management Information System. **Goal:** 400 patient interventions Milestone 3 Estimated Incentive Payment: $740,592 **Milestone 4** CQI P-5: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric P-5.1: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source Documentation of weekly or bi-weekly phone	**Milestone 5** I-7: Increase access to disease prevention programs using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to disease prevention programs but are not required. Metric I-7.2: Increased number of encounters as defined by intervention (e.g., screenings, education, outreach, etc Total number of interventions for reporting period. **Goal:** 500 patient interventions Data Source VNA, Rescue Mission, UMC Registry Data, OASIS system , EHR, claims or other homeless management information system source Milestone 5 Estimated Incentive Payment: $1,485,490	**Milestone 6** I-7: Increase access to disease prevention programs using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to disease prevention programs but are not required. Metric I-7.2: Increased number of encounters as defined by intervention (e.g., screenings, education, outreach, etc.) Increase patients enrolled in VNA Shelter Nursing Program at Rescue Mission. **Goal:** 600 patient interventions Data Source VNA, Rescue Mission, UMC Registry Data, OASIS system , EHR, claims or other homeless management information system source Milestone 6 Estimated Incentive

138951211.2.2	***2.7.6***	138951211.2.10.1	**Rescue Mission / VNA Shelter Program for the Homeless**
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): *OD-11 Addressing Health Disparities in Minority Populations*	IT-11.6 (PPR 30 Day Readmissions for target homeless population discharged to the Rescue Mission with chronic conditions that include but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension)	138951211.3.10	OD-11 Addressing Health Disparities in Minority Populations IT-11.6 (PPR 30 Day Readmissions for target homeless population discharged to the Rescue Mission with chronic conditions that include but not limited to diabetes, obesity, hepatitis C, cirrhosis / liver disorders and hypertension)

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)**
agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $678,853	meetings, conference calls, or webinars, including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $740,592		Payment: $1,227,144
Year 2 Estimated Milestone Bundle Amount: $1,357,706	Year 3 Estimated Milestone Bundle Amount: $1,481,184	Year 4 Estimated Milestone Bundle Amount: $1,485,490	Year 5 Estimated Milestone Bundle Amount: $1,227,144
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,551,523			

93652

Project Option 2.9.1 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized healthcare: **DISCHARGE FACILITATION / NAVIGATION FOR HIGH-RISK PATIENTS**

Unique Project ID: 138951211.2.3
Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

Intervention(s): This is a new program for UMC. This project will create specific case management positions to discharge our Medicaid and Unfunded patients with chronic conditions to appropriate medical homes for follow-up healthcare treatment utilizing other UMC projects that will provide for clinic growth and expansion, as well as appropriate home health care services, and finally coordinating homeless and transient patients to our partner homeless residential facilities. This project will ensure the coordination and continuity of health care as patients transfer between different locations.

Need for the project: This project will create a coordinated system of care upon discharge within the hospital. UMC expects that the effective targeting and navigation of high-risk and chronic care patients will greatly reduce or eliminate return emergency room visits while also reducing hospital inpatient days for this population. This project will also increase patient awareness of self-care best practices and increase support inside and outside of the hospital for discharged patients.

Target population: The target population is our patients with Congestive Heart Failure, Renal Failure, Hypertension, Obesity, and Diabetes., Our indigent and unfunded patients will be provided with medical homes and home health care as needed. This project will serve at least 1,174 patients during DY3, DY4 and DY5, and the number of visits per patient could multiply that number exponentially for total impact of the program. Each patient will receive an in-hospital assessment, and in-home assessment and a minimum of three follow-up phone calls.

Category 1 or 2 expected patient benefits: This project seeks to increase the number of patients reached established during DY3 (350) as a baseline by 20% in DY4 (420) and DY5 (504).

Category 3: This project will be measured with outcome domain OD-11 Addressing Health Disparities in Minority Populations IT-11.5 Other Outcomes Target (IT-3.1 30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program).

Project Description:

Under this project, UMC El Paso will develop a patient care navigation system to facilitate discharges for high-rick patients to assist in self-management education and coordination with local community groups and resources.

This project will identify high-risk patients based on chronic conditions and history of readmissions, and create/amend staff positions to facilitate the discharge of these patients to include RNs, physicians, case managers, social workers, and other appropriate practitioners in the hospital setting. The project will specifically target patients with diabetes, renal disease, history of stroke, obesity, and other populations with a history of readmissions. Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge.

Goals and Relationship to Regional Goals:

Project Goals: Ensure that hospital discharges are accomplished appropriately and that care transitions occur effectively and safely. Dedicate full-time RNs to facilitate discharge for high-risk patients, in an effort to assure that these patients receive instructions and education about self-care, and support for social and emotional issues related to discharge; engage UMC social workers to use the Cerner system to consult with high-risk patients, and their physicians and nurses, to review and identify needs at discharge; coordinate with local community groups to place patients after discharge, thus keeping track of the targeted patients subsequent to discharge to provide support and monitor health status; finding community members to coordinate the discharges with in the community.

This project meets the following regional goals: This project meets several regional goals, including increased access to primary care through the expansion of medical homes, primary care clinics, and more effective care navigation upon discharge; better managing patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, Epilepsy, and Renal disease to help prevent unnecessary readmission and get patients the care they need to prevent, self-manage, and address in an appropriate setting; and providing patient education to ensure the population is accessing the right care in the right setting.

Challenges:

Hospital readmissions are both costly and common. Health care professionals are all tasked with treating the patient quickly and moving the patient through the system and discharging as soon as possible. This is done to reduce cost, prevent complications, and even aide in customer satisfaction. Unfortunately, many times the patient is discharged with a list of instructions to do and necessary follow up, but for many reasons, they are unable to complete the necessary follow up and return to the emergency room and possibly end up back in the hospital. Patients who have a clear understanding of their discharge instructions and home care, including how to take their medications and when to follow up with their primary care physician do not return to the emergency room Knowing that they have an appointment in a short period of time give the patient and family the sense of security they will have the necessary follow up they need.

5-Year Expected Outcome for Provider and Patients:

This project will create a coordinated system of care upon discharge within the hospital. UMC expects that the effective targeting and navigation of high-risk and chronic care patients will greatly reduce or eliminate return emergency room visits while also reducing hospital inpatient days for this population. This project will also increase patient awareness of self-care best practices and increase support inside and outside of the hospital for discharged patients.

Starting Point/Baseline:

Nurse Discharge Navigators can coordinate with the local community to obtain appropriate placement of discharged patients with chronic diseases requiring management and monitoring; target patients with diabetes, renal disease, history of stroke, obesity, and other populations with a history of readmissions. Once the assessment determines the need to hire Discharge Navigators, patients will be identified and enrolled in the care transition protocol developed in this project. Baseline will be determined.

Rationale:

Patients with chronic disease are often at high risk for hospital readmission due to an inability to engage in self-care and/or a lack of psycho/social support upon and after discharge from an inpatient stay. RNs can provide discharge instructions and education about the physical components of leaving the hospital (including diet, medication management, wound care, worsening symptoms, etc.), and can facilitate the use of case managers and/or social workers to provide support to discharged patients for the non-physical aspects of their recovery and/or maintenance of health status. Social workers can, in turn, use the Cerner system to integrate a patient's full electronic records and seek the involvement of the appropriate hospital practitioners to provide guidance during the discharge process. The Discharge Navigation Nurse (DNN) would also be able to assist the patient in obtaining a clinic appointment if they were not able to do so within one month of discharge.

Project Components:

The implementation of this project at UMC El Paso will accomplish the following core project components (a-e):

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

- **In DY 2 UMC will provide report identifying the following (P-1.1)**
  - Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).
  - Gaps in services and service needs.
  - How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).
  - Ideal number of patients targeted for enrollment in the patient navigation program
  - Number of Patient Navigators needed to be hired
  - Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients

b) Deploy case managers/workers as patient navigators.

- In DY 3, UMC with hire patient navigators (P-2.1)

c) Connect patients to primary and preventive care.

- In DY 3, UMC will establish a patient navigator program (P-3.1)

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

- As a part of the navigator program, UMC will include education in self-management and increase access to chronic care management for these patients.

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.

- UMC will conduct quality improvement activities as part of the care navigation program established under this project.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care
- CN-3: Diabetes

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

This project will establish a patient care navigator program. UMC will hire and train care navigators to target and manage high-risk patients with chronic diseases. This new program will identify these patients and ensure that they are receiving the follow-up care, self-management instructions, and support they need in the community. Transitional care (discharge navigation) is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations

IT-11.5 (IT-3.1) Other Outcomes Target (30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program)

Reasons/rationale for selecting the outcome measures:

UMC believes that when patients with chronic diseases are put in contact with a nurse-navigator, the outcome will include better follow-up care, better self-management, and a greater awareness of resources in the community. This knowledge base will cause the patients to seek the appropriate care in the appropriate setting, rather than utilizing the Emergency Department as their first point of contact. This will lower the rate of potentially preventable readmissions for those that are enrolled in the patient navigator program.

Relationship to other Projects: UMC has several other projects focused on patients with chronic conditions and high-risk patients, including expanding the chronic care management model at UMC's Neighborhood Health Clinics (138951211.2.5)

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Texas Tech is also proposing a project to better-manage this population through a disease management registry (084597603.1.3). Las Palmas Del Sol also has a project for a diabetes management registry (094109802.1.1).

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the challenges in establishing a new program, hiring additional personnel to support the navigation program, and ongoing costs associated with managing this high-risk patient population. This project also has a potential savings to the overall healthcare delivery system because there are significant costs and health complications that can be avoided when a patient population receives the right care in the right setting, rather than utilizing the Emergency Department as its primary healthcare resource. This project will significantly address the needs of the El Paso community by providing high-risk patient with chronic diseases information on self-management and existing resources in the community.

UMC also evaluated this project based on the patient and community benefit that is enhanced by providing ongoing care after the patient with a chronic condition is discharged in order to prevent costly readmissions and ER visits, as well as preventing a decline in the patient's condition. The amount of patients in the community with chronic conditions (e.g. Diabetes) is extraordinarily high and managing this condition alone would create a healthier community and one empowers to manage their condition effectively. Providing focused assistance and care after hospital discharge to the underfunded community is a valuable benefit that will lead to healthier lifestyles for this target population.

138951211.2.3	***2.9.1***	2.9.1 a-e	***DISCHARGE FACILITATION/NAVIGATION TO HIGH-RISK PATIENTS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-11	IT-11.5	138951211.3.11	Other Outcomes Target (IT-3.1 30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program)

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 to identify the patient population(s) to be targeted with the Patient Navigator Program Metric [P-1.1]: Provide report identifying targeted patient population characteristics(under/unfunded patients); how the program will identify, triage, and manage patient population; number of navigators needed to be hired (2) Data Source: Program documentation, EHR, claims, needs assessment survey , Care Transitions Program Baseline Goal: We anticipate hiring transitions coordinator and case manager. Milestone 1 Estimated Incentive Payment: $1,527,419 **Milestone 2** [CQI 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[CQI P-6.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the	**Milestone 3** [P-2]: 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. Metric [P-2.1]: Number of people trained as patient navigators (4), number of navigation procedures, or number of continuing education sessions (12) for patient navigators. Data Source: Workforce development plan for patient navigator recruitment, training and education Care Transitions Program Baseline Goal: Hire 2 additional patient navigators and attend 12 continuing education sessions. Milestone 3 Estimated Incentive Payment: $1,110,888 **Milestone 4** [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 Numerator: Number of targeted patients	**Milestone 6** [I-10] Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric [I-10.1] Increase percentage of target population reached: Numerator: Number of individuals of target population reached by the Patient Navigator Program. Denominator: Number of individuals in the target population Baseline/Goal: Increase target population reached by 20% (420) Data Source: Documentation of target population reached, as designated in the project plan. Milestone 6 Estimated Incentive Payment: $3,342,352	**Milestone 7** [I-10] Improvements in access to care of patients receiving patient navigation services using innovative project option Metric [I-10.1] Increase percentage of target population reached: Numerator: Number of individuals of target population reached by the Patient Navigator Program. Denominator: Number of individuals in the target population Baseline/Goal: Increase target population reached by 20% over DY4 (504) Data Source: Documentation of target population reached, as designated in the project plan. Data Source: EHR, claims Milestone 7 Estimated Incentive Payment: $2,761,073

138951211.2.3	***2.9.1***	2.9.1 a-e	***DISCHARGE FACILITATION/NAVIGATION TO HIGH-RISK PATIENTS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-11	IT-11.5	138951211.3.11	Other Outcomes Target (IT-3.1 30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program)

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 participated in. Baseline Goal: 2/month once project is approved webinars, phone conferences, meetings. 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. Milestone 2 Estimated Incentive Payment: $1,527,419	enrolled in the program Denominator: Total number of targeted patients identified Baseline/Goal: Baseline of 350 people enrolled. Increase number of patients enrolled in program by 10%. Data Source: Enrollment reports Milestone 4 Estimated Incentive Payment: $1,110,888 **Milestone 5** [CQI 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[CQI P-6.1]: Number of bi-weekly meetings, conference calls, or webinars (26) organized by the RHP that the provider participated in. 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. Baseline Goal: 2/month Milestone 5 Estimated Incentive Payment: $1,110,888		

138951211.2.3	***2.9.1***	2.9.1 a-e	***DISCHARGE FACILITATION/NAVIGATION TO HIGH-RISK PATIENTS***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-11	IT-11.5	138951211.3.11	Other Outcomes Target (IT-3.1 30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program)

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: $3,054,838	Year 3 Estimated Milestone Bundle Amount: $3,332,664	Year 4 Estimated Milestone Bundle Amount: $3,342,352	Year 5 Estimated Milestone Bundle Amount: $2,761,073
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $12,490,927			

93635

Project Option 2.1.1 Enhance/Expand Medical Homes: **NHC MEDICAL HOME EXPANSION**

Unique Project ID: 138951211.2.4
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a/ University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso.

Intervention: The medical home model will be fully implemented in the UMC neighborhood health centers, which will result in better coordination of care, greater access, and enhanced quality of patient care. Development of a patient registry including layered reporting of performance measures and decision support so that cost, access and quality are measurable and improvement can be demonstrated.

Need for the Project: Currently care at NHC is reactive instead of proactive and planned. Multiple studies have shown that increased access to planned, proactive primary care and support staff and greater involvement of the patient in making their own health care decisions improve total health care 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.

Target Population: Patients utilizing the UMC Neighborhood Health Centers

Category 1 or 2 expected patient benefits: NHC will obtain Medical Home Recognition.
300 new patients assigned to medical home will be contacted for their first patient visit within 60-120 days. We expect this project to improve the quality of care given by establishing a medical home for 3442 patients in Y2 at Ysleta and Fabens, 8250 patients in Y3, 9500 patients in Y4 and 10583 patients in Y5 for a total of 31,775 patients now cared for under the medical home model.

Category 3 outcomes: OD-11 Addressing Health Disparities in Minority Populations; IT. 11.5 – Other readmission rate.
IT-3.12 Select any other category 3 outcome and target specific minority population.
Patients discharged from UMC with a diagnosis of diabetes to the UMC NHC Medical Home.

Project Description:

This project will increase coordination of patient's care in a medical home environment and increase patient loyalty to their medical home. The project will seek to obtain Medical Home Certification for each of the Neighborhood Health Center sites, and create a patient registry.

Target Zip Codes: 79907, 79927, 79849, 79838, 79928, 79912, 79922, 79932, 79936, 79935.

Goals and Relationship to Regional Goals:

Project Goals: The medical home model will be fully implemented in the UMC neighborhood health centers, which will result in better coordination of care, greater access, and enhanced quality of patient care. Development of a patient registry including layered reporting of performance measures and decision support so that cost, access and quality are measurable and improvement can be demonstrated.

This project meets the following regional goals: This project meets the regional goal of providing services on the full healthcare continuum. Allowing patients to have a central location to access primary and specialty care will reduce unnecessary ED admissions and provide primary care in a clinic setting that is utilized by uninsured and indigent populations. This project will assist in getting patients assigned to a medical home as a resource to access the much-needed primary and specialty care support that is in short-supply throughout the region.

Challenges:

The challenges involve philosophical changes to the practice; expand staff and staff roles and implementing the requirements to acquire Medical Home Certification for all NHC sites. Creating a shared patient registry among the clinics will require coordination and training for the staff at the NHCs as well as integration with the existing EMR system. A medical Home Coordinator will be hired to provide ongoing training for staff and assure certification goals are met. A patient registry system that coordinates with our EMR will be purchased and data entry will be implemented with reports going to each provider.

5-Year Expected *Outcome for Provider and Patients:*

We expect that the Neighborhood Health Centers will achieve patient centered medical home NCQA recognition helping to document better care coordination and better health outcomes for the patients they serve.

Starting Point/Baseline:

The Neighborhood Health Centers are just beginning the implementation of the patient centered medical home model. The baseline will be zero from program inception.

Rationale:

Region 15 has identified expansion of Primary care as its first priority in its community needs, designating it as CN.1, and secondary care as its second priority, CN.2, as shown below. Increasing patients' assignment to a medical home will improve not only access to primary care, but also provide long-term health care outcomes due the patients' continuous access to preventative and ambulatory care. This project will serve the community by getting patients access to care in the right place, right setting, reducing inappropriate ED admission, and cost avoidance of inpatient treatment for care that is better served in an ambulatory setting.

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.[21]

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care.

Project Components: 2.1.1 Develop, implement, and evaluate action plans to enhance / eliminate gaps in the development of various aspects of PCMH standards:

The establishing a new primary care medical home will accomplish the following core project components (a-d):

a) Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness.
    - During DY2, UMC will perform a gap analysis to determine readiness.

b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
    - During DY2, UMC will perform a feasibility study to determine readiness.

c) Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
    - During DY 2 and DY 3, UMC will conduct educational sessions to inform physicians, staff, and leadership of the rationale and vision of PCMH.

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.
    - CQI Milestone: P-8 Participate in at least biweekly interactions with other HP to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

[21] http://www.pcpcc.net/content/pcmh-vision-reality

- CN.1
- CN.2
- CN.4

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

The Neighborhood Health Centers are currently providing reactive patient care instead of proactive planned care. Patient's may or may not see the same provider at their next visit. The project will provide for a patient centered medical home and patient empanelment to help patients better manage their health. A registry system will be established to help insure each patient receives the care they need. Medical Home certification will be achieved to help insure UMC-NHC is providing outstanding quality care.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations; IT. 11.5 – Other 30 day readmission rate.

IT-3.12 Select any other category 3 outcome and target specific minority population.

- Patients discharged from UMC with a diagnosis of diabetes to the UMC NHC Medical Home

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the comprehensiveness in providing primary care through the lens of the patient. Patient satisfaction with timeliness and access to information will help determine whether there is adequate access to care in the community.

Relationship to other Projects: UMC has several other projects dedicated to improving the outcomes for marginalized populations with diabetes, including 138951211.2.1: the Salvation Army and 138951211.2.2: Rescue Mission.

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

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC,

regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which Patient Centered Medical Home transforms primary care from being reactive and unplanned to systematic planned care meeting each patient's needs. It is well documented to significantly improve patient health outcomes while being cost effective in a systems approach to care. Multiple studies have shown that increased access to planned, proactive primary care and support staff and greater involvement of the patient in making their own health care decisions improve total health care costs. This project will focus on achieving the Waiver goal of improving outcomes while curbing overall healthcare costs while supporting the development of a coordinated care delivery system and improving the healthcare infrastructure. A Medical Home Coordinator will be hired to insure all staff are trained in the Medical home model. Medical Home certification will be obtained and progress will be made to reach additional levels of certification. A patient registry system will be purchased and implemented to increase quality of patient care by tracking all important indicators by disease system. By having all health care needs tracked and met for over 31,000 patients in the primary care system we will work to provide quality care while avoiding costly ED visits and hospital admissions.

138951211.2.4	***2.1.1***	2.1.1a-d	***MEDICAL HOME ENHANCEMENT AND EXPANSION – NHC***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations		IT-3.12 Select any other outcome and target specific minority population Diabetes 30 day readmission rate	138951211.3.12	Addressing Health Disparities in Minority Populations

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 clinic at two sites (Ysleta and Fabens) Metric **P-1.1** Increase number of primary care clinics using the medical home model. **Numerator:** Number of primary care clinics using the medical home model. **Goal: 2** **Denominator**: Total number of primary care clinics = 4 Data Source Documentation of the increased number of primary care clinics using the medical home model **Patient Impact**: 3442 patients Milestone 1 Estimated Incentive Payment: $961,708 **Milestone 2** **P-3** Reorganize staff into primary care teams responsible for the coordination of primary care at Ysleta and Fabens Metric **P-3.1** Document Primary Care Teams Numerator: Number of staff organized into care teams. Goal: 50% or 24	**Milestone 4** **P-1** Implement the medical home model in primary care clinic at two sites (East and Crossroads) Metric **P-1.1** Increase number of primary care clinics using the medical home model. **Numerator:** Number of primary care clinics using the medical home model. **Goal: 4** **Denominator**: Total number of primary care clinics = 4 Data Source Documentation of the increased number of primary care clinics using the medical home model **Patient Impact**:8250 patients Milestone 4 Estimated Incentive Payment: $1,049,172 **Milestone 5** **P-3** Reorganize staff into primary care teams responsible for the coordination of primary care at East and Crossroads Metric **P-3.1** Document Primary Care Teams	**Milestone 7** **I-18** Obtain Medical Home recognition by a nationally recognized agency for NHC sites. Metric **I-18.1** Medical Home recognition / accreditation **Numerator:** number of sites or clinics receiving recognition / accreditation. **Goal: 2** **Denominator:** Total number of sites or clinics eligible for recognition= 4 Data Source Documentation of Medical Home recognition / accreditation from a nationally recognized agency **Patient Impact**: 9500 patients Milestone 7 Estimated Incentive Payment: $3,156,666	**Milestone 8** **I-13** New patients assigned to medical homes receive their first appointment in a timely manner Metric **I-13.1** Improve number of new patients assigned to medical home that are contacted for their first patient visit within 60-120 days. **Numerator:** number of new patients contacted within specified day. Goal: 300 **Denominator:** Total number of new patients=600 Data Source Scheduling systems, registry, EMR, etc. **Patient Impact**: 9500 patients Milestone 8 Estimated Incentive Payment: $2,607,680

138951211.2.4	***2.1.1***	2.1.1a-d	***MEDICAL HOME ENHANCEMENT AND EXPANSION – NHC***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations		IT-3.12 Select any other outcome and target specific minority population Diabetes 30 day readmission rate	138951211.3.12	Addressing Health Disparities in Minority Populations

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)**
Denominator: Total number of staff=48 Data Source Documentation of staff assignment into care teams Milestone 2 Estimated Incentive Payment *(maximum amount)*: $961,708 **Milestone 3** **CQI: P-12** Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects Metric **P-12.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in Data Source Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Hold two meets each month Milestone 3 Estimated Incentive Payment *(maximum amount)*: $961,708	Numerator: Number of staff organized into care teams. Goal: 9 Denominator: Total number of staff=18 Data Source Documentation of staff assignment into care teams Milestone 5 Estimated Incentive Payment *(maximum amount)*: $1,049,172 **Milestone 6** **CQI: P-12** Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects Metric **P-12.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in Data Source Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Hold two meets each month Milestone 6 Estimated Incentive Payment: $1,049,172		

138951211.2.4	***2.1.1***	2.1.1a-d	***MEDICAL HOME ENHANCEMENT AND EXPANSION – NHC***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations		IT-3.12 Select any other outcome and target specific minority population Diabetes 30 day readmission rate	138951211.3.12	Addressing Health Disparities in Minority Populations
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: $2,885,124		Year 3 Estimated Milestone Bundle Amount: $3,147,516	Year 4 Estimated Milestone Bundle Amount: $3,156,666	Year 5 Estimated Milestone Bundle Amount: $2,607,680
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $11,796,986				

93655

Project Option 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: **EXPAND CHRONIC CARE MANAGEMENT MODEL PROGRAMS AND SERVICES AT THE UMC NEIGHBORHOOD HEALTH CENTERS**

Unique Project ID: 138951211.2.5
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso.

Intervention: New Project - Diabetes Chronic Care - This project will redesign the outpatient delivery system to coordinate care for patients with chronic diseases and improve patient outcomes, with a focus on diabetic patients**.** We will coordinate an appointment for Diabetic patients within 4 days from discharge at UMC to UMC-NHC for patients without a PCP or NHC patients. Utilizing the Chronic Care Model and a team approach including PCP, Pharmacist, Registered Dietitian, Social Worker and Exercise Physiologist we will create a comprehensive medical home for Diabetic patients, track their process in a registry system and help the patient increase their understanding of diabetes and establish their own self-management goals.

Need for the Project: UMN-NHC are currently not utilizing the Chronic Care Model nor has a specialized diabetic program upon discharge from UMC despite having a large number of diabetic patients who would benefit from a more systematic approach to helping them manage their diabetes.

Target Population: Patients with diabetes being discharged from UMC to the UMC Neighborhood Healthcare Centers will receive proactive, ongoing care in the outpatient setting that helps them control their diabetes, improves their wellbeing and empowers them to self-manage their own goals, thereby improving their health status and/or keeping their health status from worsening, and allowing these patients to avoid ED and inpatient care.

Category 1 or 2 expected patient benefits: Reach 2260 new patients receiving care under the chronic care model at UMC's neighborhood health centers (NHCs).

Category 3 Outcomes:

OD-11 Addressing Health Disparities in Minority Populations
IT-3.3 Diabetes 30-day readmission rate, for patient population receiving diabetes care under chronic care model at neighborhood health centers (NHCs).

Project Description:

This project will redesign the outpatient delivery system to coordinate care for patients with chronic diseases and improve patient outcomes, with a focus on diabetic patients.

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. The six components of this model include: decision support, delivery system design, information systems, community resources and policies, organization of health care, and self-management support

Following the components of the model, under this project UMC will expand the care teams tailored to the needs of the applicable patient population, redesign systems, base care on evidence-based clinical protocols, and improve the use of patient registry systems. Throughout the implementation of this project, UMC will work to ensure that patients are active partners in health care decision-making, that health care leadership is actively involved in the process, and that community participation is increased. The program will target diabetic patients, with an emphasis on those who are post-discharge, delivering care to them under the chronic care model by means of UMC's already-existing neighborhood health centers (NHCs).

In order to accomplish each component of this project, UMC will 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. UMC will ensure that patients can access these care teams in person or by phone or e-mail. UMC will increase patient engagement and empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions. Finally, UMC will ensure that high-quality care is delivered to patients under this project by conducting quality improvement activities following the projects initial implementation.

Goals and Relationship to Regional Goals:

Project Goals: The ultimate goal of this project is for patients with diabetes to receive proactive, ongoing care in the outpatient setting that improves their wellbeing and empowers them to self-manage their own goals, thereby improving their health status and/or keeping their health status from worsening, and allowing these patients to avoid ED and inpatient care. Post-discharge patients will be particularly targeted to ensure that they are receiving appropriate care as they rebuild their health.

This project meets the following regional goals: This project meets the regional goal of increasing patient satisfaction through delivery of high-quality, effective healthcare services. This project will meet this goal by providing better, evidence-based care through UMC's neighborhood health centers (NHCs). The project also meets the regional goal of better management of patients of chronic diseases such as diabetes, by providing diabetes patients with

ongoing care and care management through implementation of the chronic care model at NHCs. Finally, the project meets the regional goal of addressing the issue of diabetes, which the RHP has determined is a major health concern in the region.

Challenges:

Redesigning systems is always a challenge, and the institution of evidence-based clinical protocols is difficult for some providers to adjust to. Effective utilization of patient discharge processes and outpatient scheduling for "planned" care needs to be upgraded. Helping patients to become more empowered in the healthcare decision process is often difficult for both patient and provider due to the need for education and empowerment.

5-Year Expected Outcome for Provider and Patients:

UMC expects that this redesigned outpatient delivery system will work more effectively with diabetes patients. The project will promote improved patient outcomes, decreased readmissions, increased patient engagement and patient self-management goal setting, improved patient-provider communication, and better coordination with community resources. Year 2 Develop program, hire staff and train. Year 3 520 Year 4 700 Year 5 1040 new diabetic patients will be discharged into this program. Each year we will continue the care of the existing program participants for a total of 2260 new patients impacted over the four years. These services will also help improve the care of our existing diabetic patients.

Starting Point/Baseline:

None of UMC's neighborhood health centers (NHCs) is currently using the Chronic Care Model. The associated Medical Home Project will bring system-wide upgrades across the NHC sites. This project is focusing specially on the Diabetic patient subset and working more intensively on their specific healthcare needs.

Rationale:

The chronic care model has been proven to help redesign systems to provide more effective outpatient care.

Project Components:

This project will accomplish the following 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.
    - UMC will develop care teams as necessary to provide care under the chronic care model at UMC's neighborhood health centers (NHCs).

b) Ensure that patients can access their care teams in person or by phone or e-mail.

- UMC will develop methods of access to care teams that will ensure patients have the ability to access their care teams in a variety of ways.

c) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources.

- UMC will develop and implement patient engagement activities throughout the life cycle of this project.

d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.

- UMC will develop and implement components of this project with the purpose of empowering patients.

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.

- UMC will conduct quality improvement activities following the initial implementation of the project, to ensure that patients receive high-quality care under this project.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care
- CN-3: Diabetes
- CN-6: Other Projects

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

This project will significantly enhance the care provided to El Paso residents through UMC's neighborhood health centers (NHCs), by improving the quality of the care provided at the NHCs. Currently, UMC's NHCs do not provide chronic care based on the chronic care model.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations

IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated

disparity in the particular measure—IT-3.12 Other readmission rate, for patient population under chronic care model at neighborhood health centers (NHCs)

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the improvement in readmission rates for patients receiving diabetes care under the chronic care model from UMC's neighborhood health centers (NHCs). Because the purpose of the project is ultimately to improve the delivery of care in the setting where it is most appropriate, UMC believes this outcome measure will accurately track whether or not the project has been successful in its primary goal, from the perspective of the patients to whom the services are provided.

Relationship to other Projects: This project is one of several UMC projects which aim to improve the quality and availability of primary care and specialty care services in the El Paso community, including Establishing the Crossroads Clinic in Southwestern El Paso (138951211.1.3); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary care and specialty care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which the provision of diabetes and other specialty care under the chronic care model at UMC's neighborhood health centers (NHCs) will address the community's needs, the population served, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because diabetes and other specialty care services will be available under this project to patients when and where they need it, in a community-based setting, thereby reducing or eliminating the need for such patients to seek care for their chronic conditions in an ED or inpatient setting, and reducing the likelihood of readmission for those patients who have been discharged and enrolled in chronic care at an NHC. Additionally, providing these services at the appropriate time and an appropriate place makes it more likely that a patient's chronic health problems will be addressed before greater complications can develop, leading to better outcomes and less costly treatment.

138951211.2.5	***2.2.1***	2.2.1.a-e	**EXPAND CHRONIC CARE MANAGEMENT MODEL PROGRAMS AND SERVICES AT THE UMC NEIGHBORHOOD HEALTH CENTERS**
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD – 11	***IT-11.5 – 3.12 Other Readmission Rate***	138951211.3.13	***Select Any Other Category 3 Outcome*** IT-3.12 Other readmission rate, for patient population under chronic care model at neighborhood health centers (NHCs)

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]: Expand the Chronic Care Model to primary care clinics. Metric 1 [P-1.1]: Increase number of primary care clinics using the Chronic Care Model. Baseline/Goal: Implement the Chronic Care Model at 4 UMC neighborhood health centers (NHCs). Data Source: Documentation of practice management. Milestone 1 Estimated Incentive Payment: $622,282 **Milestone 2** [P-2]: 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. Numerator: Number of relevant staff trained in the chronic care model. Goal: 20% Denominator: total number of relevant staff – baseline: 66	**Milestone 4** [P-7]: Develop disease-specific or multiple chronic condition (MCC) Medical Home. Metric 1 [P-7.1]: Develop a pilot project to establish a primary care entity for people who have the condition or MCC. Baseline/Goal: Establish chronic care at UMC neighborhood health centers (NHCs) for diabetes patients serving 520 new patients. Data Source: Patient medical records at the pilot clinic. Milestone 4 Estimated Incentive Payment: $1,018,314 **Milestone 5** [CQI P-12]: 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 1 [P-12.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.	**Milestone 6** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.1]: Increase percentage of target population reached. Baseline/Goal: reach 700 new patients for a total of 1250 patients Data Source: Documentation of target population reached, as designated in the project plan. Milestone 6 Estimated Incentive Payment: $2,042,548	**Milestone 7** [P-19]: Implement disease-specific or multiple chronic condition (MCC) Medical Home. Metric 1 [P-19.2]: Monitor clinically appropriate indicator of disease improvement. Baseline/Goal: reach 1040 new patients for a total of 2260 patients receiving care under the chronic care model at UMC's neighborhood health centers (NHCs). Data Source: Patient medical records at NHCs. Total patient benefit 4030 Milestone 7 Estimated Incentive Payment: $1,687,323

138951211.2.5	***2.2.1***	2.2.1.a-e	**EXPAND CHRONIC CARE MANAGEMENT MODEL PROGRAMS AND SERVICES AT THE UMC NEIGHBORHOOD HEALTH CENTERS**
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD – 11	***IT-11.5 – 3.12 Other Readmission Rate***	138951211.3.13	***Select Any Other Category 3 Outcome*** IT-3.12 Other readmission rate, for patient population under chronic care model at neighborhood health centers (NHCs)

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: 30% improvement over DY1 for all staff at NHC . No Staff are currently trained. The goal is to train all staff at NHC Data Source: HR; training program materials. Milestone 2 Estimated Incentive Payment: $622,282 **Milestone 3** [CQI P-12]: 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 1 [P-12.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: two meetings per month 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.	Goal: two meetings per month 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. Milestone 5 Estimated Incentive Payment: $1,018,314		

138951211.2.5	***2.2.1***	2.2.1.a-e	**EXPAND CHRONIC CARE MANAGEMENT MODEL PROGRAMS AND SERVICES AT THE UMC NEIGHBORHOOD HEALTH CENTERS**
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD – 11	***IT-11.5 – 3.12 Other Readmission Rate***	138951211.3.13	***Select Any Other Category 3 Outcome*** IT-3.12 Other readmission rate, for patient population under chronic care model at neighborhood health centers (NHCs)

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 3 Estimated Incentive Payment: $622,281			
Year 2 Estimated Milestone Bundle Amount: $1,866,845	Year 3 Estimated Milestone Bundle Amount: $2,036,628	Year 4 Estimated Milestone Bundle Amount: $2,042,548	Year 5 Estimated Milestone Bundle Amount: $1,687,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,633,344			

93657

Project Option 2.11.2.A Evidence-based interventions that put in place the teams, technology, and processes to avoid medication errors—Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations: **CONDUCT MEDICATION MANAGEMENT—ESTABLISH A COUMADIN CLINIC AT UMC NEIGHBORHOOD HEALTH CENTERS**

Unique Project ID: 138951211.2.6
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider**:** University Medical Center of El Paso currently provides four outpatient primary care facilities in the El Paso area serving Region 15, known as UMC Neighborhood Healthcare Centers. They are strategically located throughout El Paso County in high need areas as guided by our mission and strategic plan. Our health centers are all accredited by the Joint Commission and all physicians are Board Certified and are experts in their fields - Family Practice, Internal Medicine and Pediatrics. We are in the process of developing new clinics, as well as expanding services and hours of operation at our existing sites to better serve the patients in need in El Paso.

Intervention: New Project - Establish a Coumadin Clinic - Services to be provided include: establishment of a medical home, patient assessment, monitoring of anticoagulation, warfarin dosage adjustment, medication education and management, patient education (including nutrition counseling and self-management), and follow-up care. The clinic will increase patient well-being and satisfaction, and reduce the number of readmissions to treat stroke and coronary artery disease and warfarin-related bleeding.

Need for the Project: Currently there is no Coumadin Clinic in the El Paso area for uninsured/ Medicaid patients. UMC currently is discharging 6-10 patients every week in this category or patients who do not have an established Primary Care Provider. The is a very dangerous situation due to the complexity of the patient's health status following discharge on this medication.

Target Population: UMC discharged patients' status post-stroke or post-coronary artery disease event or other condition discharged on Coumadin to the UMC-NHC.

Category 1 or 2 expected patient benefits: 30% improvement over DY1of the number of patients receiving medication management from acute care to the ambulatory setting.
50% of Coumadin patients with electronic medication reconciliation implemented

Category 3 Outcomes: OD-11 Addressing Health Disparities in Minority Populations
IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT-3.12 Other readmission rate: coronary artery disease and stroke 30-day readmission rate for patient population receiving care from Coumadin clinics at neighborhood health centers (NHCs)

Project Description:

This project will establish a Coumadin Clinic at UMC's neighborhood health centers (NHCs).

Under this project, UMC will establish a Coumadin Clinic at UMC's neighborhood health centers (NHCs). Services to be provided by this Coumadin Clinic will include: establishment of a medical home, patient assessment, monitoring of anticoagulation, warfarin dosage adjustment, medication education and management, patient education (including nutrition counseling and self-management), and follow-up care. The clinic will increase patient well-being and satisfaction, and reduce the number of readmissions to treat stroke and coronary artery disease and warfarin-related bleeding.

This clinic will help reduce readmissions of patients discharged after stroke or coronary artery disease event. Additionally, UMC will continue to refine and improve the operations of the Coumadin Clinic by conducting quality improvement activities following the implementation of the clinic.

Goals and Relationship to Regional Goals:

Project Goals: The goal of this project is to improve overall patient health status post-stroke or post-coronary artery disease event. The project will accomplish this broad goal by improving patient management of Coumadin intake.

This project meets the following regional goals: This project meets the regional goal of better managing patients with chronic diseases. Patients with chronic conditions that necessitate Coumadin intake will be able to better manage their conditions, in cooperation with UMC providers, as a result of this project.

Challenges:

Establishing the clinic will require training staff to work as a team around this condition in a collaborative partnership. It will also require UMC to hire additional staff to cover the current staff's present patient load. UMC will need to obtain a dedicated clinical location and allocate time on the applicable staffing schedule, provide transportation when appropriate, coordinate clinic processes with hospital discharge process to refer appropriate patients, and notify the relevant patient population that the clinic exists and of the benefits to making use of it. It is expected that this clinic will need to grow exponentially and that services will need to expand to each clinic site.

5-Year Expected Outcome for Provider and Patients:

As a result of this project, UMC expects an increase in positive patient outcomes and better accomplishment of treatment goals. UMC also expects a reduction in deterioration of medical conditions and resulting hospital readmissions. We expect to serve approximately 260 new patients each year for a total of 1040. We estimate that each patient will average 2.5 prescriptions

each year or 650 prescriptions. Total prescriptions reconciled for the four years will be 2600. We will implement electronic prescription writing by the start of DY3. In DY4 350 prescriptions will be electronically sent and in DY5 520 will be electronically sent for a total of 870 prescriptions sent electronically.

Starting Point/Baseline:

This is a new clinic for UMC-NHC. Therefore the baseline is 0 for patient utilization. The wait time for patients needing Coumadin follow-up care post hospitalization could be as long as 90 days in the current El Paso market, and maybe longer for underfunded patients.

Rationale:

Coumadin is a widely prescribed anticoagulant, used to prevent heart attacks, strokes, and blood clots. Coumadin can result in serious side-effects for patients, and does not interact well with many other common (and over-the-counter) medications. For this reason, it is imperative that Coumadin users be continuously monitored, well-educated, and have their dosage adjusted if and when their condition or side-effects warrant a change. Studies have shown that self-testing leads to better therapy outcomes, which means that patients need the ability and equipment to take this step. Access into a Coumadin clinic or comprehensive treatment program in the El Paso area is extremely limited for patients who do not have private insurance.

Project Components:

This project will accomplish the following project component:

a.) Implement a medication management program that serves the patient across a continuum of care targeting one or more chronic disease patient populations

- UMC will implement electronic prescription from NHCs which expedites prescription availability while ensuring accuracy and avoiding contraindications

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

This project will significantly enhance the care provided to El Paso residents through UMC's neighborhood health centers (NHCs), by adding Coumadin medication management services to the menu of care options that are available to patients outside of the inpatient or ED setting.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations

IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT.312 - Other readmission rate: coronary artery disease and stroke 30-day readmission rate for patient population receiving care from Coumadin clinics at neighborhood health centers (NHCs)

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the improvement in readmission rates for patients receiving Coumadin management services from UMC's neighborhood health centers (NHCs). Because a key purpose of the project is ultimately to improve the delivery of care in the setting where it is most appropriate, UMC believes this outcome measure will accurately track whether or not the project has been successful in its primary goal, from the perspective of the patients to whom the services are provided.

Relationship to other Projects: This project is one of several UMC projects which aim to improve the quality and availability of primary and specialty care services in the El Paso community, including Establishing the Crossroads Clinic in Southwestern El Paso (138951211.1.3); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4). UMC's NHC Quality Improvement infrastructure project (138951211.1.7) will enable UMC to effectively conduct quality improvement activities as part of this project.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary and specialty care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which the provision of Coumadin clinic services at UMC's neighborhood health centers (NHCs) will address the community needs, the population served, resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because Coumadin management services and related support will be available under this project to patients when and where they need it, thereby reducing complications and reducing the likelihood of readmission. Additionally, providing these services at the appropriate time makes it more likely that a patient's chronic health problems will be addressed before greater complications can develop, leading to better outcomes and less costly treatment.

138951211.2.6	2.11.2	2.11.2a	***CONDUCT MEDICATION MANAGEMENT***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations	***IT-11.5 Select PPR for Coumadin Patients discharged to NHC; IT-3.12 Other 30 day Readmission Rate – Stroke and coronary artery disease***	138951211.3.14	***Addressing Health Disparities in Minority Populations:*** IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT.3.12 - Other readmission rate: coronary artery disease and stroke 30-day readmission rate for patient population receiving care from Coumadin clinics at neighborhood health centers (NHCs)

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 1 [P-2.1]: Establish evidence-based criteria for medication management planning in target population based on an assessment of population needs. Baseline/Goal: Establishment and documentation of criteria. Data Source: Written criterion for target population and program participation. Milestone 1 Estimated Incentive Payment: $848,566 **Milestone 2** [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 at Ysleta Metric 2 [P-4.1]: Written plan to provide medication management and	**Milestone 4** [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 at Fabens and Montwood Metric 4 [P-4.1]: Written plan to provide medication management and continuity between acute care and ambulatory setting Data Source: Submit written Plan, EHR Goal: A new program for electronic medication reconciliation. Milestone 4 Estimated Incentive Payment: $1,388,610 **Milestone 5** [CQI P-8]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and	**Milestone 6** [I-11]: Increase the number of patients receiving medication management from acute care to the ambulatory setting. Metric 6 [I-11.1]: Percent of discharged patients who received medication reconciliation as part of the transition from acute to ambulatory care. Numerator: Number of discharged Coumadin patients who received medication reconciliation at NHC. Denominator: Number of Discharged Coumadin Patients received at NHC Baseline/Goal: 350 Coumadin patients with medication reconciliation implemented Data Source: EHR; discharge data. Milestone 6 Estimated Incentive Payment: $1,392,647 **Milestone 7** [I-12]: Implement electronic prescription writing at the point of care.	**Milestone 8** [I-11]: Increase the number of patients receiving medication management from acute care to the ambulatory setting. Metric 8 [I-11.1]: Percent of discharged patients who received medication reconciliation as part of the transition from acute to ambulatory care. Data Source: EHR; discharge data. Baseline/Goal: 520 Coumadin patients with medication reconciliation implemented Total prescriptions reconciled for the four years will be 2600. Milestone 8 Estimated Incentive Payment: $2,300,894

138951211.2.6	2.11.2	2.11.2a	***CONDUCT MEDICATION MANAGEMENT***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations	***IT-11.5 Select PPR for Coumadin Patients discharged to NHC; IT-3.12 Other 30 day Readmission Rate – Stroke and coronary artery disease***	138951211.3.14	***Addressing Health Disparities in Minority Populations:*** IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT.3.12 - Other readmission rate: coronary artery disease and stroke 30-day readmission rate for patient population receiving care from Coumadin clinics at neighborhood health centers (NHCs)

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)**
continuity between acute care and ambulatory setting Data Source: written plan Goal: Written plan Expected patient benefit: 260 new patients a year will have 2.5 medications each reconciled for a total of 650 medications. Milestone 2 Estimated Incentive Payment: $848,566 **Milestone 3** [CQI P-8]: 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 3 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.	the RHP to promote collaborative learning around shared or similar projects. Metric 5 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. 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. Goal: Hold two meetings monthly Milestone 5 Estimated Incentive Payment: $1,388,610	Metric 7 [I-12.1]: Increase the number of new and refill prescriptions written and generated electronically. Numerator: Number of new and refill prescriptions written and generated electronically Denominator: Number of new and refill prescriptions written in a specified time period. Baseline: Approximately 780 Coumadin patients at NHCs who have 2.5 Rx's each=1900 Rx. Baseline time period: Implementation of electronic prescription writing at the point of care. One fourth of Coumadin patient records implemented = 195 Data Source: Paper or electronic health record. Milestone 7 Estimated Incentive Payment: $1,392,646	

138951211.2.6	2.11.2	2.11.2a	***CONDUCT MEDICATION MANAGEMENT***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD-11 Addressing Health Disparities in Minority Populations	***IT-11.5 Select PPR for Coumadin Patients discharged to NHC; IT-3.12 Other 30 day Readmission Rate – Stroke and coronary artery disease***	138951211.3.14	***Addressing Health Disparities in Minority Populations:*** IT-11.5 Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT.3.12 - Other readmission rate: coronary artery disease and stroke 30-day readmission rate for patient population receiving care from Coumadin clinics at neighborhood health centers (NHCs)

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: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars, including agendas for phone calls, slides from webinars, and/or meeting notes. Goal: Hold two meetings monthly Milestone 3 Estimated Incentive Payment: $848,566			
Year 2 Estimated Milestone Bundle Amount: $2,545,698	Year 3 Estimated Milestone Bundle Amount: $2,777,220	Year 4 Estimated Milestone Bundle Amount: $2,785,293	Year 5 Estimated Milestone Bundle Amount: $2,300,894
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $10,409,106			

93658

Project Option 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: **COMPLETE HOSPICE CARE FOR UNCOMPENSATED PATIENTS**

Unique Project ID: 138951211.2.7
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

Intervention(s): This is a new program. This project will discharge hospice appropriate indigent patients to Hospice El Paso while also aiding UMC physicians, residents, case managers, and social workers through the on-going scheduled hospice/palliative care education sessions conducted by Hospice El Paso's medical directors and staff.

Need for the project: Currently, many hospitals and especially teaching hospitals could benefit from ongoing education regarding proper hospice consults and providing care in the right setting for the dying patient. UMC anticipates an increase in hospice consults due to this project and also will secure the proper setting for patients who are unfunded instead of dying in the institutional setting. This project will allow UMC to better utilize the heavy demand for its acute care rooms for other types of severe case, while also greatly reducing return to emergency room visits and inpatient days. It will also enable staff to identify hospice appropriate patients on the general medical and surgical units due to the training and education of this workforce.

Target population: The target population is our palliative care to be transitioned to hospice care, and specifically the unfunded population.

Category 1 or 2 expected patient benefits: This project seeks to increase the number of palliative care patients established during DY2 (180) of hospice appropriate admissions (1965) as a baseline by 10% in DY4 (198) and that there will be a 20% increase in DY5 from the DY2 baseline (216). Our goal is a 30% increase in training of workforce (70 physicians, 26 case management staff) or approximately 29 persons. Category 3: The outcome domain for this project is OD-13 Palliative Care IT-13.4 Proportion admitted to the ICU in the last 30 days of life, although the scope of training and hospice consults will be throughout the hospital units.

Project Description:

Under this project, UMC El Paso will enter into a contract to transition all hospice-appropriate uncompensated patients into hospice services.

Under this project, UMC El Paso will contract with Hospice of El Paso, a 33-year-old non-profit hospice provider, to transition all hospice-appropriate uncompensated UMC patients into the services of Hospice of El Paso. Hospice of El Paso will also provide hospice/palliative care education sessions for attending physicians, residents, case managers, and social workers. The patients covered by this program will also include hospice-appropriate patients needing acute care and/or ventilator support, as well as hospice-appropriate pediatric patients. Hospice appropriate patients may include, but are not limited to those with diagnoses of Alzheimer's Disease, Bladder Cancer, Breast Cancer, Colon Cancer, Liver Cancer, Ovary Cancer, Prostate Cancer, Stomach Cancer, Cirrhosis, Chronic Obstructive Pulmonary Disease, Cerebro-Vascular Accident, Debility, Dementia, Failure to Thrive, Liver Disease, Parkinson's, Pulmonary Fibrosis, Renal Failure and Congestive Heart Failure.

As part of the negotiating and contracting process with Hospice of El Paso, UMC will develop a business case for palliative care, showing that the implementation of this project will be financially beneficial for patients and/or payors. In order to ensure that high-quality care is provided to patients under this program, UMC will administer patient/family satisfaction surveys and also will conduct quality improvement activities related to hospice services and palliative care.

Goals and Relationship to Regional Goals:

Project Goals: UMC intends for this project to improve patient outcomes and quality of life for hospice-appropriate patients. Consistent with the priorities of hospice treatment and palliative care, the goal of this project is relief and prevention of suffering for hospice-appropriate patients.

This project meets the following regional goals: This project meets the regional goals of overcoming language, socio-economic, and monetary barriers to accessing healthcare resources in the region, and of increasing patient satisfaction through delivery of high-quality, effective healthcare services. The project will expand the provision of hospice services and palliative care to socio-economic groups which previously did not have access to such care, and the project will also increase patient satisfaction by providing care which is appropriate to the needs of the hospice-appropriate patient population.

Challenges:

Major challenges which must be addressed in order to successfully implement this project include the high volume of uncompensated hospice-appropriate patients at UMC, as well as the transaction costs involved in negotiating and executing a contract between UMC and Hospice of El Paso. Challenges will be addressed by training of physician specialties, case managers and

social workers in hospice and palliative care. This will facilitate a smoother transition of the patient from acute care to hospice/palliative care.

UMC does not have a hospice/palliative care education program currently. Hospice El Paso will provide UMC with scheduled hospice/palliative care education sessions for attending physicians, residents, case managers, and social workers. The on-going programs will be presented by HEP's medical directors and staff to include one director who is certified in Palliative Care (One of only two in El Paso County) and has 24 years of hospice experience.

The education presentations will help physicians in their 'end of life' conversations with the patient while it is proven to help with the quality of life for the patient and also limits the use of intensive interventions.

5-Year Expected Outcome for Provider and Patients:

UMC expects that the transition of hospice-appropriate UMC patients to hospice services will greatly reduce or eliminate return emergency room visits while also reducing hospital inpatient days for this population. These patients will receive hospice care from highly-trained specialists in palliative care, whether at home, at an assisted living facility, at a long-term care facility, foster home, or at Hospice of El Paso's acute care facility. Ventilator support will be provided for patients who are ventilator-dependent. Patients will experience a much better quality of life, and their families will receive the support they need. The cost of care and the cost burden on UMC will be reduced.

Starting Point/Baseline:

A large minority of the uncompensated and Medicaid population of UMC patients is hospice-appropriate but does not currently receive hospice services or palliative care. We will establish a baseline of those patients at UMC that do not have a funding source to allow for transfer out to appropriate end of life palliative care

- Begin training for providers on hospice/palliative consults for discharges
- Establish number of UMC patients who are hospice appropriate that did not have hospice consults
- Measure hospice patients who were provided with pain screening measures

Rationale:

Hospice affirms life and regards dying as a normal process. Hospice neither hastens nor postpones death. Hospice provides personalized services so that patients and families can attain the necessary preparation for a death that is satisfactory to them.

Those involved in the process of dying have a variety of physical, spiritual, emotional, and social needs. The nature of dying is so unique that the goal of the hospice team is to be sensitive and responsive to the special requirements of each individual and family.

Hospice care is provided to patients who have a limited life expectancy. Although most hospice patients are cancer patients, hospices accept anyone regardless of age or type of illness. These patients have also made a decision to spend their last months at home or in a homelike setting**.**

This project will allow for UMC to transfer terminally ill patients (both compensated and uncompensated) out of acute or critical rooms to Hospice of El Paso's acute care facility, "The Center for Compassionate Care." Here they will receive 24-hour, highly-specialized and focused attention from a medical staff that specializes solely in critical palliative care.

This project will allow UMC to better utilize the heavy demand for its acute care rooms for other types of severe cases, while also greatly reducing return emergency room visits and impatient days for the population to be served by the project. The contract with Hospice of El Paso also allows for UMC to refer hospice appropriate uncompensated patients to Hospice of El Paso services, which services will also include specialized care for ventilator-supported and pediatric patients. These palliative care services will likewise result in significant reductions of inpatient days, repeat admissions, and emergency room visits for the relevant patient populations.

Project Components: 2.10.1 Implement a palliative care program to address patients with end of life decisions and care needs

The implementation of this project at UMC El Paso will accomplish the following core project components (a-d):

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program.

   - UMC will develop a palliative care business case and conduct planning activities as part of the negotiation and contracting process with Hospice of El Paso.

b) Transition palliative care patients from acute hospital care into home care, hospice, or a skilled nursing facility.

   - UMC will transition palliative care patients from UMC hospital care to the care of Hospice of El Paso.

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.

   - UMC will implement a patient/family experience survey as part of this project, to be administered to the population of patients served by the project, and their families.

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.

- UMC will conduct quality improvement activities as part of the hospice program established under this project.

Unique community need identification numbers the project addresses:

- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

This project will significantly enhance the hospice and palliative care services available to unfunded and underfunded patients in the El Paso community. Through their collaboration, UMC and Hospice of El Paso will make it possible for a patient population to receive the sensitive and appropriate care which they need and which they were previously unable to obtain.

Related Category 3 Outcome Measures:

OD-13: Palliative Care

IT-13.4 Proportion admitted to the hospital in the last 30 days of life

Reasons/rationale for selecting the outcome measures:

A large minority of the uncompensated and Medicaid population of UMC patients are hospice-appropriate but do not currently receive hospice services or palliative care outside of the hospital bed setting. We will provide for those patients at UMC that do not have a funding source to allow for transfer out to appropriate end of life palliative care.

Relationship to other Projects: UMC has several other projects dedicated to expanding access to primary or specialty care, including Establishing the Crossroads Clinic in South-western El Paso (138951211.1.3); Enhancing Quality Improvement in the UMC NHCs (138951211.1.7); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion

of access to primary or specialty care in the community for those patients who currently experience financial, geographic, or other barriers to accessing the care they need.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the costs and health complications that can be avoided when a patient population receives the right care in the right setting, rather than being forced to utilize the Emergency Department as its primary healthcare resource. This project will significantly address the needs of the El Paso community by providing uninsured and underinsured patients with hospice care which is currently unavailable to them. Transition into Hospice care is extremely cost efficient compared to that of a hospital. In a 2009 comparison study published in the Social Security Administration Bulletin (using Bureau of Labor Statistics) the number was $6,200 to $152.

138951211.2.7	***2.10.1***	2.10.1(a-d)	***COMPLETE HOSPICE CARE FOR UNCOMPENSATED PATIENTS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-13 Palliative Care	***IT-13.4 Proportion admitted to the Hospital in the last 30 days of life***	138951211.3.15	***OD-13 Palliative Care*** ***IT-13.4 Proportion admitted to the Hospital in the last 30 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-8]: Document the conditions for which palliative care is consulted. Metric 1 [P-8.1]: Breadth of conditions for which palliative care is utilized. **Numerator:** Number of chronic conditions for which the palliative care patients are consulted (180) **Denominator:** Total number of patients admitted with chronic conditions or MCC (1965) Baseline/Goal: The baseline is 180 patients. Data Source: EHR; palliative care database/ case management database Milestone 1 Estimated Incentive Payment: $1,103,136 **Milestone 2** [CQI P-9]: 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 1 [P-9.1]: Number of bi-weekly meetings, conference calls, or webinars	**Milestone 3** [P-2]: Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties), in providing palliative care including non-cancer training. Metric 1 [P-2.1]: Primary care specialties training and education in palliative care. Baseline/Goal: Educate 30% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields (70), case managers (14) and social workers (12) goal of 29 persons ,by DY5. Data Source: Database that tracks type and number of training and education sessions by health professional category (ICU, family medicine, Internal Medicine, Geriatrics, and other IM subspecialties). Training and Education Materials, dates of trainings and attendance Milestone 3 Estimated Incentive Payment: $1,203,462 **Milestone 4** [CQI P-9]: Participate in		**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. Metric 1 [I-9.1]: Transitions accomplished. **Numerator**: Number of palliative care discharges to hospice, homecare, or SNF **Denominator:** Total number of palliative care discharges (180) Baseline/Goal: 10% increase over DY2 to increase hospice appropriate consults and discharges (198). Data Source: EHR; data warehouse; palliative care database. Milestone 5 Estimated Incentive Payment: $2,413,921	**Milestone 6** [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 Metric 1 [I-9.1]: Transitions accomplished. **Numerator**: Number of palliative care discharges to hospice, homecare, or SNF **Denominator:** Total number of palliative care discharges Baseline/Goal: 20% increase over DY2 to increase hospice appropriate consults and discharges (216). Data Source: EHR; data warehouse; palliative care database. Milestone 6 Estimated Incentive Payment: $1,994,108

138951211.2.7	***2.10.1***	2.10.1(a-d)	***COMPLETE HOSPICE CARE FOR UNCOMPENSATED PATIENTS***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD-13 Palliative Care	***IT-13.4 Proportion admitted to the Hospital in the last 30 days of life***	138951211.3.15	***OD-13 Palliative Care IT-13.4 Proportion admitted to the Hospital in the last 30 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)**
organized by the RHP that the provider participated in. 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 Milestone 2 Estimated Incentive Payment: $1,103,136	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 1 [P-9.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: n/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 Milestone 4 Estimated Incentive Payment: $1,203,462			
Year 2 Estimated Milestone Bundle Amount: $2,206,272	Year 3 Estimated Milestone Bundle Amount: $2,406,924		Year 4 Estimated Milestone Bundle Amount: $2,413,921	Year 5 Estimated Milestone Bundle Amount: $1,994,108
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,021,225				

93656

Project Option 2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population: **DEVELOP SURGERY GUIDEBOOK FOR PATIENTS AND CORRESPONDING NURSE ADVICE LINE**

Unique Project ID: 138951211.2.8
Performing Provider Name/TPI: The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC) / TPI: 138951211

Project Summary:

Provider: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

Intervention(s): This is a new program for UMC. Under this project, UMC will develop an educational guidebook for surgical patients, including resources for pre-surgery, intra-surgery, post-surgery, discharge, and follow-up. UMC will create a 24/7 nurse advice line for surgical patients to access with questions and concerns. We will tailor the nurse advice line to be able to give more detailed support regarding the same issues and questions addressed by the surgery guidebook.
DY 2 This program will hire 3 Registered Nurses. Each Nurse will make 700 interactions; Surgery Guide Book, Advice Line and post discharge/follow up phone call.
DY 3 This program will hire 4 additional Registered Nurses. Each Nurse will make 700 interactions Surgery Guide Book, Advice Line and post discharge/follow up phone call.
.
The above FTE numbers do not include the Nurse Manager and Office Coordinator.

*This project will impact approximately 18,858 patients during the term of the waiver.

DY 2 approximately 2,100 interactions including Surgery Guide Book, Nurse Advice Line and post discharge/follow up phone call.
DY 3 approximately 4,900 interactions including Surgery Guide Book, Nurse Advice Line and post discharge/follow up phone call.
DY 4 approximately 5,390 interactions including Surgery Guide Book, Nurse Advice Line and post discharge/follow up phone call.
DY 5 approximately 6,468 interactions including Surgery Guide Book, Nurse Advice Line and post discharge/follow up phone call.

. Need for the project: We currently do not have a program such as this in place to proactively address post-surgical issues, and to offer additional assistance to patients via the nurse advice line. Patients return to the ER with common issues that could be addressed at home or through preventative education (guidebook / advice line) to prevent unnecessary infections.

Target population: This project will target the population of surgery patients at UMC, providing them with the information and resources that are crucial for effective pre-surgery and post-surgery care transitions.

. Category 1 or 2 expected patient benefits: Following the development of the surgery guidebook materials and the implementation of the nurse advice line, UMC will conduct quality improvement activities to ensure that the services provided to UMC surgery patients through this project are of the highest quality. UMC expects that this project will result in an improvement in pre-surgery and post-surgery self-care within the targeted patient population, as well as greater patient awareness of risks, benefits, and best practices when undergoing surgical procedures.

Category 3 outcomes: OD-11 IT 11.5 IT-3.12 Other Readmission Rate (30 Day Readmission Rate) (Post-Surgical Patients Discharged from UMC). Our goal is to reduce readmissions for preventable conditions associated with surgery.

Project Description:

Under this project, UMC will develop an educational guidebook for surgical patients and a corresponding nurse advice line.

Under this project, UMC will develop an educational guidebook for surgical patients, including resources for pre-surgery, intra-surgery, post-surgery, discharge, and follow-up.

Additionally, UMC will create a 24/7 nurse advice line for surgical patients to access with questions and concerns. UMC will tailor the nurse advice line to be able to give more detailed support regarding the same issues and questions addressed by the surgery guidebook.

This project will target the population of surgery patients at UMC, providing them with the information and resources that are crucial for effective pre-surgery and post-surgery care transitions.

Following the development of the surgery guidebook materials and the implementation of the nurse advice line, UMC will conduct quality improvement activities to ensure that the services provided to UMC surgery patients through this project are of the highest quality.

Goals and Relationship to Regional Goals:

Project Goals: The goals of this project are to develop a surgery guidebook and to implement a corresponding nurse advice line.

This project meets the following regional goals: This project meets the regional goal of establishing more effective care navigation upon discharge. While the surgery guidebook will contain information relevant to both pre-surgery and post-surgery patients, this project will be

particularly useful to post-discharge patients, because it will allow them to obtain answers to their questions either by consulting the guidebook or by speaking with a knowledgeable nurse via the 24-hour nurse advice line. It will not be necessary for patients to return to the hospital or its ED in order to obtain this information.

Challenges:

UMC will need to assess and anticipate patient questions and concerns in order to develop appropriate and relevant material for inclusion in the guidebook and in the advice line documentation. UMC will also need to evaluate resources available to patients in order to recommend them to patients through the guidebook and advice line. UMC will have to hire new staff or reschedule existing staff in order to properly staff the advice line on a 24/7 basis. Finally, the implementation of these information-sharing initiatives will be made more difficult by the language barriers faced by some groups within the population to be targeted by this project.

5-Year Expected Outcome for Provider and Patients:

UMC expects that this project will result in an improvement in pre-surgery and post-surgery self-care within the targeted patient population, as well as greater patient awareness of risks, benefits, and best practices when undergoing surgical procedures. UMC also expects that the project will reduce readmissions for preventable conditions associated with surgery.

Starting Point/Baseline:

UMC does not currently provide a surgery guidebook to its surgery patients, nor does it provide them with access to a 24/7 nurse advice line.

Rationale:

Beyond the risks associated with surgical procedures in and of themselves, there is a great risk that patients will suffer from conditions secondary to the surgery, such as infection. It is important that patients understand the general risks of surgery and the benefits of following a strict regimen of self-care pre-surgery and post-surgery. There are a host of resources in the El Paso community through which patients can access support for pre-surgery and post-surgery self-care. However, this information is not being effectively communicated to the patients who could benefit most from such resources, because there is no comprehensive guide providing such information. This is especially detrimental for elderly and indigent patients who are less likely to have access to online resources and who are less able to travel outside their homes for outpatient care. Beyond the guide, for patient-specific questions or for those people who cannot use the guidebook for various reasons, patients currently do not have access to providers in the region for questions regarding pre-surgery and post-surgery best practices. *The average cost for a surgical readmission is $10,684.00 , Source: Journal of the American College of Surgeons; Volume 213, Issue 3, Supplement, page 106, September 2011.

Project Components:

This project will accomplish the following project component:

a) 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.

   - UMC will conduct quality improvement activities following the initial implementation of the project, to ensure that patients receive high-quality care under this project.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

This project will significantly enhance the care provided to UMC patients undergoing surgery by providing them with information which they need in order to experience effective pre-surgery and post-surgery care transitions. Currently, this information either does not exist or is not provided to the patients who need it in an organized and accessible way.

Related Category 3 Outcome Measures:

OD-11 Addressing Health Disparities in Minority Populations

IT-11.5 (IT3.12) Other Readmission Rate (Post Surgical Patients Discharged from UMC in this program) – 30 Day Readmission Rate

Reasons/rationale for selecting the outcome measures:

This outcome measure was chosen to measure the improvement in readmission rates for patients receiving information and self-care support through the surgery guidebook and the corresponding nurse advice line. Because the purpose of the project is ultimately to reduce complications associated with a pre-surgery and post-surgery lack of proper self-care and of effective care transitions, UMC believes the success of the project can be accurately measured by the readmission rate for the population of patients which receive services under the project

Relationship to other Projects: Like UMC's Discharge Navigation and Electronic Medical Records projects (138951211.2.3; 138951211.1.2), this project is primarily aimed at improving

care transitions for a designated population of patients in the El Paso community. Additionally, this project is one of several which is intended to make primary care resources more accessible in the El Paso community; these related projects include Establishing the Crossroads Clinic in Southwestern El Paso (138951211.1.3); Expanding Primary Care at Ysleta and Fabens (138951211.1.5); and Expansion and Enhancement of Medical Homes at UMC NHCs (138951211.2.4).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: Providence and Sierra East are also developing projects to support the expansion of access to primary care and specialty care in the community.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

In determining the value of this project, UMC considered the extent to which the more effective and accessible provision of pre-surgery and post-surgery self-care information and support will address the community's needs, the population served, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). This project will focus on achieving the Waiver goal of improving outcomes while curbing healthcare costs, because the services to be provided under the project will reduce or eliminate the need for post-surgery patients to seek care for their chronic conditions in an ED or inpatient setting, and reducing the

likelihood of readmission for those patients who have been discharged and enrolled in chronic care at an NHC. Additionally, providing these services at the appropriate time and an appropriate place makes it more likely that a patient's chronic health problems will be addressed before greater complications can develop, leading to better outcomes and less costly treatment.

138951211.2.8	***2.12.2***	2.12.2	***DEVELOP SURGERY GUIDEBOOK FOR PATIENTS AND CORRESPONDING NURSE ADVICE LINE***	
University Medical Center of El Paso				*138951211*
Related Category 3 Outcome Measure(s): OD - 11	***11.5***	138951211.3.16	OD-3 Potentially Preventable Re-Admissions – 30 Day Readmission Rate IT-3.12 Other Readmission Rate (Post Surgical Patients Discharged from UMC) – 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-1]: Develop or implement best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions. Metric 1 [P-1.1]: Care transitions protocols. Baseline/Goal: Hire 3 RNs and 1 Nurse Manager 1 Office Coordinator Develop care transitions protocols. Approximately 700 interactions for each of the three RNs including; Surgery Guide Book , Advice Line and post discharge/follow up phone call. TOTAL= 2,100 interactions. Data Source: HR Documentation, Protocols, database of interactions Milestone 1 Estimated Incentive Payment: $1,018,279 **Milestone 2** [CQI P-10]: Participate in	**Milestone 3** [P-2]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transition policies and procedures. Baseline/Goal: Hire 4 additional RNs . Approximately 700 interactions for each of the RNs including ; Surgery Guide Book, Advice Line and post discharge/follow up phone call. TOTAL: 4,900 interactions. Data Source: HR Documentation, Policies and Procedures, database of interactions Milestone 3 Estimated Incentive Payment: $1,110,888 **Milestone 4** [CQI P-10]: 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.	**Milestone 5** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care, and services as dictated by approved and evidence-based care guidelines Denominator: Number of patients discharged or eligible for care transition services. Goal: 10% improvement over of starting point of patients enrolled in post surgical discharge program Data Source: Registry; EHR report/analysis. Milestone 5 Estimated Incentive Payment:	**Milestone 6** [I-14]: Implement standard care transition processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes. Numerator: Number of patients in defined population receiving care according to standard protocol Denominator: Number of population patients discharged. Goal: 20% improvement over of starting point of patients enrolled in post surgical discharge program Data Source: Registry, HER report/analysis. Milestone 6 Estimated Incentive Payment: $1,840,716

138951211.2.8	***2.12.2***	2.12.2	***DEVELOP SURGERY GUIDEBOOK FOR PATIENTS AND CORRESPONDING NURSE ADVICE LINE***
University Medical Center of El Paso			*138951211*
Related Category 3 Outcome Measure(s): OD - 11	***11.5***	138951211.3.16	OD-3 Potentially Preventable Re-Admissions – 30 Day Readmission Rate IT-3.12 Other Readmission Rate (Post Surgical Patients Discharged from UMC) – 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)**
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 1 [P-10.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: 2/Month 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. Milestone 2 Estimated Incentive Payment: $1,018,279	Metric 1 [P-10.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: 2/Month 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. Milestone 4 Estimated Incentive Payment: $1,110,888	$2,228,235	
Year 2 Estimated Milestone Bundle Amount: $2,036,558	Year 3 Estimated Milestone Bundle Amount: $2,221,776	Year 4 Estimated Milestone Bundle Amount: $2,228,235	Year 5 Estimated Milestone Bundle Amount: $1,840,716
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,327,284			

93626

Project Option 2.8.1 – Applying LEAN principles to Hospital Throughput to improve Emergency Department throughput and reduce admission process times.

Unique Project ID: 138951211.2.9 Pass 2
Performing Provider Name/TPI: University medical Center of El Paso / 138951211

Project Summary:
Provider: University Medical Center of El Paso (UMC), a Major Safety Net Hospital, serves the highest percent of unfunded patients in Region 15. It is licensed for 394 beds. While the population of the Region is approximately 800,000, the healthcare providers serve an estimated population of 2.6 million residents in a multi-national region. Approximately 25% of El Paso County population lives below the federal poverty level, and the majority of patients served by UMC, about 65%, are either enrolled in Medicaid or are underfunded. Payor mix includes 20% Medicaid, and 45% Indigent, Uninsured, and Underinsured. UMC operates the only Level I Trauma facility within 280-miles of the city, and is also the only academic medical center in the region, serving as the teaching hospital for Texas Tech University Health Sciences Center Paul L. Foster School of Medicine's (TTUHSC) Residency and Fellowship programs.

The National Public Health and Hospital Institute reports the average length of stay in the Emergency Department (ED) for patients admitted to the hospital to be 7.8 hours. (NPHHI, *DataBrief* April 2011) In 2012 a total of 10,257 patients were admitted to UMC through the ED with an average ED length of stay of 11.35 hours.

Intervention(s): UMC will develop a plan to establish LEAN principles to expedite the admission process from the Emergency Department. UMC has an established agreement with TTUHSC's Department of Internal Medicine to streamline their consultation workflow process. UMC will continue this relationship with TTUHSC, and expand our LEAN / Kaizen Principles by contracting with a second university, the University of Texas at El Paso (UTEP), for LEAN Consultation services and training to be implemented in patient care areas, to include the ED. As part of this project, we will evaluate whether expansion of the program will be feasible and effective. If the project is found to have merit, an evaluation will be conducted and the results reviewed. UMC may secure Hospitalists to collaborate between teaching-teams and the non-teaching service to facilitate the admission process from the ED to the inpatient setting. In addition, UMC's inpatient discharge process will be a focus to improve the average time of discharge and open inpatient beds earlier in the day. Resident rounding will be reassessed to support paced discharges and improve efficiency.

Need for the project: The ED demonstrates an annual census of approximately 55,000 patients with an admission rate of 18%. We expect each demonstration year to affect over 10,000 patients that will be admitted to UMC through the Emergency Department. In 2012 the average ED length of stay for a patient admitted to the hospital was 11.35 hours (11:21 hrs). When the admission process was broken down further one contributing factor identified was a cumbersome and lengthy admit process. The average time from when the Admit Order was placed to the time Patient Placed in Inpatient Bed was over 213 minutes. We plan to streamline the admission

process from the ED to inpatient units to reduce admission process times and shorten the LOS for ED admissions thereby improving the patient's experience in our facility.

Target population: The target population will include all inpatients at UMC as well as admissions to the hospital originating in the ED. An efficient discharge process for UMC inpatients will vacate inpatient beds for awaiting patients from the ED. Currently 65% of UMC patients are either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: The expected benefits to our patients is an improved ED throughput by shortening the admission process from the ED,. This project will also reduce the total Length of Stay (LOS) for admissions originating in the ED and improve Customer Satisfaction scores for the ED. Through this project, UMC will identify at least two new operational procedures needed to improve overall efficiencies in patient care management and intend to demonstrate a 7.35% improvement by DY5.

Category 3 outcomes: Improvement in throughput will be accomplished through a series of process improvements starting with the admission process in the ED. The goal is to reduce the average LOS for admission from the ED by 5% (34 minutes) over initial baseline by end of year four and demonstrate an overall improvement of 7.35% (50 minutes) over initial baseline by the end of year five. Furthermore, the consultation and admission process will be managed more efficiently through improvements made within the Hospitalist program. Further, improvement in the admission process will occur through simplification of the hospital admission process to reduce the time the physician enters the order to "Admit" to the time the "patient arrives on the inpatient unit." Another goal is to demonstrate improvement in the average time of discharge for inpatients by 25 minutes from initial baseline by end of year four and by 45 minutes from initial baseline by the end of year five. This will further increase hospital capacity during late hours when most admissions are occurring.

Project Description:

To improve throughput within the ED by implementing LEAN manufacturing principles to a healthcare delivery system at UMC, a major trauma center, to improve process flow.

Goals and Relationship to Regional Goals:

The four-year expected outcome is to improve ED throughput by implementing systemic actions to improve the process for admissions occurring in the ED, reducing the total LOS for admissions originating in the ED, and improving Customer Satisfaction scores for the ED. UMC will test this process weekly

This project meets the Regional goals of increasing patient satisfaction through delivery of high-quality, effective healthcare services, and providing the full continuum of healthcare services, including emergent care.

Challenges:

The primary challenge for this project will be to implement an admission process that works collaboratively with traditional teaching Residency programs to facilitate the movement of the patient out of the ED upon decision to admit a patient. As the teaching hospital for TTUHSC,

challenges are anticipated in improving admission process due to the level of Residency programs operating in our facility. The current process relies on Consultant Residents responding to ED to evaluate and work up potential admissions, extending the time by waiting for admission orders. It will also be a challenge to establish an agreement with another local university and with the health sciences center to work collaboratively to improve admission and transfer process hospital wide beginning in the ED. Finally, UMC is the only Level-1 Trauma Center in our region and accepts transfers from West Texas and Southern New Mexico, thereby drawing away valuable nursing resources during arrival of critical trauma patients both locally and within the catchment region.

5-Year Expected Outcome for Provider and Patients: If this project proves to be feasible and effective, UMC will secure Hospitalists to collaborate between teaching-teams and the non-teaching services to facilitate the admission process from the ED. Additionally, UMC will focus on the inpatient discharge process to improve the average time of discharge and open inpatient beds earlier in the day. Resident rounding schedules will be reassessed to support paced discharges and improve efficiency. Patient outcomes will be improved by implementation of this project.

Starting Point/Baseline:

Statistical Averages for University Medical Center of El Paso.

1. Total average time Admit Order Placed to Patient Placed in Inpatient Bed = **213.14 min**
   Baseline data collection for period April-May 2012.
   c. Average time Admit Order placed to Admit Bed Request = 38.54 min.
   d. Average time Admit Bed Request to Admit Bed Assigned = 80.62 min
   e. Average time Admit Bed Assigned to Patient Placed in Inpatient Bed = 93.98 min

2. In 2012 the average Length-Of-Stay (LOS) for admissions from the ED (excluding critical care) = 11:21 hrs.

3. In Average Time of Discharge for all inpatient units is 16.594 hours = 4:36 pm.
   Baseline data collection for period September 2012.

Rationale:

The UMC ED demonstrates slower than average throughput, high wait times and high Left-Without-Being-Seen (LWBS) rates. The current admission process through the ED is cumbersome and lengthy, creating a backlog of patients in the ED waiting room. This project will improve hospital throughput for patients being admitted from the ED. By implementing LEAN manufacturing principles to a healthcare delivery system at UMC, the hospital will improve throughput and discharge efficiency, which will improve bed availability for new admissions from the ED. Utilizing Hospitalists more effectively within the ED will expedite the admission process improving the admission process, as well as reduce the need for Resident Consultants in the ED setting. The creation of a safer patient environment and increased customer service scores will result from the LEAN activities.

Project Components / Project Option:

(P-2.8.1): Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.

a. Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
   - UMC will provide LEAN classes to hospital staff involved in this process, from registration to ED to inpatient staff.

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.
   - We plan to utilize 'Kata' a systematic means for working through obstacles to achieve new conditions and levels of performance. It utilizes the PDSA cycle and makes creativity, adaptation and innovation part of your daily problem solving routine.

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).
   - Performance measures for currently designed cross functional teams called Loops 1, 2, 3 & 4. This process will be tested continuously and address new ideas, tools, or solutions.

d. Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.
   - UMC will utilize an ED Bed request to Floor admission process diagram to address this core component.

e. Implement software to integrate workflows and provide real-time performance feedback.
   - UMC will use "Teletracking" software that communicates with Cerner and Invision hospital systems throughout the implementation of this project.

f. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change process based on the results of key performance indicators.
   - UMC will utilize the newly created Hospital Throughput Steering Committee to evaluate the impact of ongoing process improvement for this project and integrate improvement processes into the Performance Improvement Committee.

Unique community need identification numbers the project addresses:

- CN-6: Other Projects

<u>Related Category 3 Outcome Measures:</u>

OD-9 Right Care, Right Setting

IT-9.4 Other Outcome Improvement Target; Overall wait times for Emergency Department patients; Reduction in Left-Without-Being-Seen rates for ED patients.

<u>Reasons/rationale for selecting the outcome measures:</u> The goal is to reduce the average LOS for admission from the ED by 5% from initial baseline by end of year 4 and demonstrate an

overall improvement of 7.35% from initial baseline by the end of year 5. The consultation and admission process will be better managed through improvements made within the Hospitalist program. Further improvement in the admission process will occur through simplification of the hospital admission process to reduce the time the physician enters the order to "Admit" to the time the "patient arrives on the inpatient unit." UMC will plan to improve the average time of discharge for inpatients by 25 minutes by end of year four and by 45 minutes by the end of year five.

Relationship to other Projects: This project will complement the UMC Psychiatric Liaison Project, and all other projects involving discharging patients.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: This project does not tie to other entities projects , as it is involves streamlining internal throughput process and benefit our patients. There are several other providers in the Region that are similarly addressing their internal inefficiencies to provide better experiences for patients in the Region.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation:

The valuation of each UMC project takes into account the degree to which the project accomplishes the triple aim of the Waiver, the degree to which the project addresses community needs, the acuity and number of patients served by the project, and the investment required to implement the project. This project also takes into account the challenges in establishing teams to troubleshoot process and system inefficiencies and the amount of resources and time involved. This project also has a potential savings to the overall healthcare delivery system because there are significant costs and health complications that can be avoided when a patient population receives timely treatment for their conditions, rather than remaining in the ED longer than

necessary. This project will address the needs of the El Paso community by providing efficient and timely care to our patients, thus freeing up additional beds for those waiting to be treated. UMC also took into consideration the patient and community benefit that is achieved by providing timely care, which is critical in preventing unnecessary decline in the patient's condition.

UNIQUE IDENTIFIER: 138951211.2.9 Pass 2	***RHP PP REFERENCE NUMBER:*** 2.8.1	***PROJECT COMPONENTS:*** 2.8.1A,B,C,D,E,F	***PROJECT TITLE:*** **Applying LEAN principles to Hospital Throughput to improve Emergency Department throughput and reduce admission process times**
Performing Provider Name: University Medical Center of El Paso			*TPI 138951211*
Related Category 3 Outcome Measure(s): OD-9 Right Care, Right Setting	IT-9.4 Other Outcome Improvement Target	138951211.3.17 Pass 2	Other Outcome Improvement Target – Overall wait times for emergency department patients, reduction in LWBS rates for emergency department patients

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-4): Define operational procedures needed to improve overall efficiencies in care management. Metric 1 (P-4.1): Report on at least two new operational procedures needed to improve overall efficiencies in care management. a. Submission of analysis findings/summary. Baseline/Goal: Expect each demonstration year to affect over 10,000 patients admitted to UMC through the Emergency Department. • Average time Admit Order to Patient in Bed = 213 mins. • Average Length of Stay for ED patients admitted = 11:21 hrs. Data source: Performing Provider report. Rational/Evidence: Improving operational procedures and reducing variation will not only help to reduce waste and redundancies, but also will help providers/staff focus on value-added work and improve quality	**Process Milestone 3** (P-1): Target specific workflows. Process and/or clinical areas to improve. Metric 3 (P-1.1): Performing Provider review and prioritization of areas or process to improve upon. a. Submission of Performing Provider report. Goal: Expect each demonstration year to affect over 10,000 patients admitted to UMC through the Emergency Department. • Average Time Discharged from inpatient bed = 4:36pm. Data Source: Static Report. Rationale/Evidence: Improving efficiencies and implementing "Paced/early Discharges" for inpatients will vacate valuable beds earlier in the day thus reducing the number of admissions held in the emergency department due to "No bed available" event. Increasing efficiencies and can help create more patient access and provider/staff capacity and enhance patient outcomes.	**Outcome Improvement Milestone 5 (I-13): Progress toward target/goal.** Metric 1 (I-13.1): Number or percent of all clinical cases that meet target/goal. Expect each demonstration year to affect over 10,000 patients admitted to UMC through the Emergency Department. Numerator: Number of relevant clinical cases at target. Denominator: Total number of relevant clinical cases. Goal: Demonstrate an overall improvement in average LOS for admission from the ED by 5% (approx 34 minutes) from initial baseline by the end of year 4. Data Source: Performing Provider report. Rational/Evidence: It is estimated that 30% of health care spending - $600-700 billion – is unnecessary and wasteful. Reducing waste and ensuring that all patients receive appropriate care, especially	**Outcome Improvement Milestone 6 (I-13): Progress toward target/goal.** Metric 1 (I-13.1): Number or percent of all clinical cases that meet target/goal. Expect each demonstration year to affect over 10,000 patients admitted to UMC through the Emergency Department. Numerator: Number of relevant clinical cases at target. Denominator: Total number of relevant clinical cases. Goal: Demonstrate an overall improvement in average LOS for admission from the ED by 7.35% (approx 50 minutes) from initial baseline by the end of year 5. Data Source: Performing Provider report. Rational/Evidence: It is estimated that 30% of health care spending - $600-700 billion – is unnecessary and wasteful. Reducing waste and ensuring that all patients receive appropriate care, especially

UNIQUE IDENTIFIER: 138951211.2.9 Pass 2	***RHP PP REFERENCE NUMBER:*** 2.8.1	***PROJECT COMPONENTS:*** 2.8.1A,B,C,D,E,F	***PROJECT TITLE:*** **Applying LEAN principles to Hospital Throughput to improve Emergency Department throughput and reduce admission process times**	
Performing Provider Name: University Medical Center of El Paso				*TPI 138951211*
Related Category 3 Outcome Measure(s): OD-9 Right Care, Right Setting	IT-9.4 Other Outcome Improvement Target	138951211.3.17 Pass 2	Other Outcome Improvement Target – Overall wait times for emergency department patients, reduction in LWBS rates for emergency department patients	
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 experience of care for patients. Increasing efficiencies and reducing variation can help create more patient access and provider/staff capacity and enhance patient outcomes. Milestone 1 Estimated Incentive Payment: $395,492 **Process Milestone 2** (P-14): Review project data and respond to it every 2 weeks 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 2 (P-14.1): Number of new ideas, practices, tools, or solutions tested by each provider/loop team. a. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider every 2 weeks. Could be summarized at quarterly intervals. b. Rationale/Evidence: The rate of testing of new solutions and ideas is	Milestone 3 Estimated Incentive Payment: $431,475 **Process Milestone 4** (P-14): Review project data and respond to it every 2 weeks 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 2 (P-14.1): Number of new ideas, practices, tools, or solutions tested by each provider/loop team. a. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider every 2 weeks. Could be summarized at quarterly intervals. b. 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. Milestone 4 Estimated Incentive		preventive serves, can result in dramatic improvements in health care efficiency and effectiveness. Finding a way to measure this impact could be very beneficial. Outcome Improvement Target 1 Milestone 5 Estimated Incentive Payment: $865,392	preventive serves, can result in dramatic improvements in health care efficiency and effectiveness. Finding a way to measure this impact could be very beneficial. Outcome Improvement Target 2 Milestone 6 Estimated Incentive Payment: $714,897

UNIQUE IDENTIFIER: 138951211.2.9 Pass 2	***RHP PP REFERENCE NUMBER:*** 2.8.1	***PROJECT COMPONENTS:*** 2.8.1A,B,C,D,E,F	***PROJECT TITLE:*** **Applying LEAN principles to Hospital Throughput to improve Emergency Department throughput and reduce admission process times**	
Performing Provider Name: University Medical Center of El Paso				*TPI 138951211*
Related Category 3 Outcome Measure(s): OD-9 Right Care, Right Setting	IT-9.4 Other Outcome Improvement Target	138951211.3.17 Pass 2	Other Outcome Improvement Target – Overall wait times for emergency department patients, reduction in LWBS rates for emergency department patients	
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)**
one of the greatest predictors of the success of a health care system's improvement efforts. Milestone 2 Estimated Incentive Payment: $395,492	Payment: $431,475			
Year 2 Estimated Milestone Bund Amount: $790,984	Year 3 Estimated Milestone Bundle Amount: $862,950		Year 4 Estimated Milestone Bundle Amount: $865,392	Year 5 Estimated Milestone Bundle Amount: $714,897
Total Estimated Incentive Payments for 4-Year Period: **$3,234,223**				

Project Option 2.12.2: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population: **STREAMLINE DISCHARGE PROCESS / ED MANAGEMENT SERVICES**

Unique Project ID: 094109802.2.1

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will establish case management and coordinated discharge planning processes; those processes will be used to identify top chronic conditions that are common causes of avoidable readmissions and develop strategies to reduce readmissions in those specific populations.

Need for the project: Currently, the ED does not have case management to be able to review unnecessary ED visits or admissions and refer to the appropriate community resources. There is also no mechanism in place to be able to track or review unnecessary ED visits. Currently, there is no case management representation in the ED and no processes in place to review unnecessary ED visits for QI purposes.

Target Population: The target population is the patients seen in our emergency departments. Many of the patients seen in the ED are unnecessarily admitted. We currently have approximately 2,028 admissions based on 2012 hospital data. We will establish a baseline in DY2 to improve upon through this project. They are also discharged from the ED without proper referrals and follow-up care with community resources that could ultimately lead to readmission into the ED. About 64% of our ED patient population is Medicaid eligible or indigent. We expect that this project will reflect a similar benefit to Medicaid eligible or indigent patients.

Category 1 or 2 Expected patient benefits: The project seeks to reduce unnecessary ED readmissions by 5% in DY4 over DY2 baseline and reduce by 10% in DY5 over DY2 baseline data for patients falling within the selected Chronic Disease categories. In DY2 and DY3, there is no direct patient impact, as we will be hiring and training case managers. All patients with these chronic conditions will be impacted by the case management services, we anticipate about 2,000 patients will be impacted in DY4, and 2,000 in DY5.
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Category 3 outcomes: IT-3.1 Our goal is to reduce the 30-day potentially preventable all-cause readmission rate by 2.5% over DY3 in DY4, and 5% over DY3 in DY5.

Project Description:

This project will establish case management and coordinated discharge planning processes; those processes will be used to identify top chronic conditions that are common causes of avoidable readmissions and develop strategies to reduce readmissions in those specific populations.

ED discharge is a prime target for improvement in the delivery of effective discharge instructions, follow-up care recommendations, referrals to community providers or resources, matching patients with appropriate community-based resources, and increasing patient satisfaction. One goal of the project is to create a mechanism to track unnecessary ED visits and admissions to the hospital and to use this mechanism to refer the patients to the appropriate community resources. This project will also incorporate the emergency screening process (ESP). ESP refers to a low-acuity strategy used to redirect non-urgent patients to appropriate alternative community resources after they have had a medical screening exam (MSE) performed by a Qualified Medical Professional (QMP).

Goals and Relationship to Regional Goals:

Project Goals: The goals of the ESP are decreased Left Prior to Medical Screening Exam (LPMSE), decreased frequent returns to the emergency department, increased community education and awareness, improved satisfaction of patients, physicians, and ED staff, and improved overall turn-around times for truly emergent conditions.

This project meets the following regional goals: This project is tied to Region 15's goal of increasing patient satisfaction through the delivery of high-quality, effective healthcare services. It is also tied to Region 15's goal of better management of patients to help prevent unnecessary readmissions and get patients the care they need to prevent, self-manage, and address in an appropriate setting.

Challenges:

Challenges include: patient participation; educating practitioners on best practices; collecting and accurately interpreting the data collected from patients; identifying the reasons behind and solutions for the most common preventable ED visits and admissions.

5-Year Expected Outcome for Provider and Patients:

By effectively implementing a case management model in the emergency rooms at LPDS, we expect to see a reduction in the potentially avoidable readmission rates. We also expect to better identify those patients with chronic conditions to provide standardized discharge instructions and patient education.

Starting Point/Baseline:

As of 2011, the ED does not have case management to be able to review unnecessary ED visits or admissions and refer to the appropriate community resources. There is also no mechanism in place to be able to track or review unnecessary ED visits. Currently, there is no case management representation in the ED and no processes in place to review unnecessary ED visits for QI purposes.

Rationale:

Case management in the emergency department would reduce overcrowding, decrease wait times, increase patient and physician satisfaction, and appropriately utilize community resources.

Case managers would also serve as a resource to the physicians and staff by providing appropriate discharge planning guidance. Additionally, poorly designed discharge processes create unnecessary stress for medical staff, causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from facility to home, or to nursing home, or to home and community-based services, etc.

Project Components:

This project will accomplish the following project components:

- Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.
    - LPDS will implement a pilot intervention in care transitions by improving its discharge process.
- Conduct quality improvement for the project using methods such as rapid-cycle improvement.
    - Following the implementation of the pilot intervention, LPDS will continue to improve the intervention by conducting quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

The project represents a new initiative, as neither emergency room at LPDS has a case management model in place. There is also no mechanism in place to be able to track or review unnecessary ED visits or readmissions.

<u>Related Category 3 Outcome Measures:</u>

OD-3 Potentially Preventable Readmissions—30-Day Readmission Rates

IT-3.1: All-Cause 30-Day Readmission Rate

094109802.3.5

Reasons/rationale for selecting the outcome measures:

This project will reduce potentially preventable admissions by implementing a case manager review model in the emergency rooms at LPDS. One goal of the project is to create a mechanism to track unnecessary admissions to the hospital and to use this mechanism to refer patients to the appropriate community resources. Also providing a better ED discharge process

will help in the delivery of the discharge instructions, follow-up care recommendations, referrals to community providers or resources, matching patients with appropriate community-based resources, and will increase patient satisfaction.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. It is one of a group of several LPDS delivery system reforms (i.e., LPDS's Primary Care Physician Recruitment (094109802.1.1), Expand Specialty Care Capacity project (094109802.2.2), and Evaluate Hospitalist Model project (094109802.2.3)) which are primarily aimed at improving models of inpatient care through the implementation of technology, provider education, quality improvement, and other means. Similarly to LPDS's Congestive Heart Failure Clinic project (094109802.2.4) and Develop Diabetes Management Registry project (094109802.1.3), this project will help individuals with specifically targeted health conditions to better manage their use of healthcare services from LPDS and other providers in the El Paso community, ensuring that the delivery and utilization of healthcare is more efficient from the provider's perspective and more effective from the patient's perspective.

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

UMC El Paso plans to implement a similar project aimed at improving discharge navigation for its patients which have been identified as high-risk.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$5,076,972. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the fact

that this project will identify populations in need of care management to ensure that the project's services will be targeted to those populations; this project has also been valued based on the need of the community in general for more effective and extensive care management in the ED setting to reduce improper utilization of emergency healthcare services.

094109802.2.1	*2.12.2*	*2.12.2*	***STREAMLINE DISCHARGE PROCESS / ED MANAGEMENT SERVICES***
HCA Las Palmas Del Sol			*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.5*	*IT-3.1*	***All cause 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-7]. Develop a staffing and implementation plan to accomplish the goals/objectives of the care transition program. Metric 1: [P-7.1]: Documentation of the staffing plan. Baseline/Goal: Currently no ED transition program. Data Source: Staffing and implementation plan. Milestone 1 Estimated Incentive Payment: $1,241,647	**Milestone 2** [P-6]: Train/designate more ED case managers. Metric 1 [P-6.1]: Number of trained and/or designated ED case managers over baseline. Baseline/Goal: Project to hire 2 ED case managers Data Source: HR; job descriptions; training curriculum. Milestone 2 Estimated Incentive Payment: $1,354,570	**Milestone 3** [I-10]: Identify the top chronic conditions (e.g., heart attack, heart failure, and pneumonia) and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of readmissions. Baseline/Goal: Report for DY4. Data Source: Registry or EHR report/analysis. Milestone 3 Estimated Incentive Payment: $679,254 **Milestone 4** [I-14]: Implement standardized care transition process in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes. Baseline/Goal: 5% improvement over DY2. Data Source: Hospital administrative data and patient medical records. Milestone 4 Estimated Incentive Payment: $679,254	**Milestone 5** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: 10% improvement over DY2. Data Source: Registry or EHR report/analysis. Milestone 5 Estimated Incentive Payment: $1,122,246
Year 2 Estimated Milestone Bundle Amount: $1,241,647	Year 3 Estimated Milestone Bundle Amount: $1,354,570	Year 4 Estimated Milestone Bundle Amount: $1,358,508	Year 5 Estimated Milestone Bundle Amount: $1,122,246

094109802.2.1	***2.12.2***	***2.12.2***	***STREAMLINE DISCHARGE PROCESS / ED MANAGEMENT SERVICES***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.5*	*IT-3.1*	***All cause 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,076,972				

95791

PROJECT REPLACEMENT

Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology, and processes to avoid medication errors—Implement Computerized Physician Order Entry (CPOE): **ELECTRONIC MEDICAL RECORDS REPLACED** with Project Option 1.9.1: Expand high impact specialty care capacity in most impacted medical specialties: **EXPAND SPECIALTY CARE CAPACITY 094109802.1.5**

Project Option 1.9.1: Expand high impact specialty care capacity in most impacted medical specialties: **EXPAND SPECIALTY CARE CAPACITY**

Unique Project ID: 094109802.1.5

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

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Project Option 2.4.3: Increased patient satisfaction: **EVALUATE HOSPITALIST MODEL**

Unique Project ID: 094109802.2.3

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will help HCA Las Palmas Del Sol research, design, and implement a hospitalist model to increase productivity and access to care for patients, involving both physicians and mid-level providers.

Need for the project: The El Paso area has a serious shortage of primary care physicians. As a result, more patients are receiving delayed care in the hospital setting and extending their hospital stay unnecessarily. The hospitalist program will improve the patient experience, expedite the delivery of care and improve the quality of life for primary care physicians.

Target Population: The target population is the inpatient population within the hospital setting. About 33% of our inpatient patient population is Medicaid eligible or indigent. We expect that this project will reflect a similar benefit to Medicaid eligible or indigent patients.

Category 1 or 2 Expected patient benefits: The project seeks to improve the number of organization-wide displays and communication of performance in the area of patient/family experience per year. The number of displays (physical or virtual) will be to increase by 2 displays over DY2 in DY4 and increase 3 displays over DY2 in DY5. We don't expect to directly serve any patients in DY2 or DY3 as a result of gathering and formulating a plan. As a result of this program the projected patient impact is approximately 14,125 patient encounters in DY4 and 14,975 in DY5.

Category 3 outcomes: IT-6.1 Our goal is to improve the patient satisfaction scores by 2.5% over DY3 in DY4, and 5% over DY3 in DY5.

Project Description:

Under this project, HCA Las Palmas Del Sol will research, design, and implement (if found to be effective) a hospitalist model to increase productivity and access to care for patients, involving both physicians and mid-level providers.

Under the current care model at our hospital, patient care is managed by individual primary care physicians who work in tandem with the hospital staff for their specific patients. Currently, there is a shortage of primary care physicians in El Paso and statewide that is causing lack of access to care. This lack of access is causing increased length of stay and decreased patient satisfaction. We would like to evaluate the possibility of implementing a hospitalist model, under which the hospital would have a staff of physicians and mid-level providers to treat hospital patients, in lieu of having primary care physicians make calls and visits on a fractured basis. Our research will

determine if an all-physician hospitalist model would be appropriate or some type of mixed-model with mid-level providers is more effective. We expect to determine if and how much a hospitalist model will improve the patient experience by creating a more stable continuity of care during a hospital stay and providing easier access to doctors and nurses.

Goals and Relationship to Regional Goals:

Project Goals: Assuming the program is feasible and desirable, we expect that the move to a hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients' diagnoses, treatment, and outcomes. The model should also improve the quality of life for physicians as they would no longer have to be on call or round in the middle of the night.

This project meets the following regional goals: This project is tied to Region 15's goal of increasing patient satisfaction through the delivery of high-quality, effective healthcare services. By providing an in-house hospitalist program, patients will receive greater access to healthcare professionals and more timely care resulting in lower lengths of stay and a better patient experience.

Challenges:

Challenges include: high cost of providing the nurses and physicians; determining whether the hospitalist model will make a positive impact for patients; convincing primary care physicians that this model is better for their patients; accurately measuring the change in patient satisfaction. This project will address the challenges by increasing the presence of Hospitalists in our facility, as well as providing training and information on how to work with a Hospitalist. Additionally, because there will be more physicians present in the hospital, patients will be seen more frequently and will have a better experience.

5-Year Expected Outcome for Provider and Patients:

The 5-year expected outcome of having a hospitalist program is to significantly increase patient satisfaction scores. These scores provide an indication of the patient experience and also help LPDS address any deficiencies in a patient's care that might prevent the best healthcare delivery possible. Higher patient satisfaction means a high-quality and effective healthcare service that is being provided.

Starting Point/Baseline:

Currently, patients are admitted to their primary care physician or the primary care physician on-call for the emergency department. Due to the shortage of primary care physicians, our physicians are over-burdened with their practice and often do not see patients in a timely manner. This causes delays in treatments which can lead to poor outcomes and increased lengths of stay. Roughly one-third of the El Paso population is under-insured or uninsured and does not have a primary care physician.

Rationale:

Implemented hospitalist 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. Currently, there is a shortage of primary care physicians in El Paso and statewide that is causing lack of access to care. This lack of access is causing increased lengths of stay and decreased patient satisfaction. We expect that the move to a hospitalist model will

improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients' diagnoses, treatment, and outcomes. Hospitalists will manage the acute care of patients and expedite the care of patients within the hospital setting. Hospitalists will ensure patients' needs are met within a timely manner. Because hospitalists are on duty 24 hours a day, they are fully available to patients from admission to discharge. This reduces complications, lengths of stay, and the costs of providing care. This model will relieve some primary care physicians from rounding in the hospital, thus enabling greater patient access to care as physicians will be able to spend more time in their practice.

Project Components:

This project will accomplish the following project components:

- Implement an innovative and evidence-based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area.
    - LPDS will improve patient satisfaction by evaluating and potentially implementing a hospitalist model.
- Conduct quality improvement for the project using methods such as rapid-cycle improvement.
    - Following the implementation of a hospitalist model, LPDS will continue to improve the model and, ideally, further improve patient satisfaction, by conducting quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

Currently there is no hospitalist program at LPDS. This would be a new initiative to be implemented by LPDS to raise patient satisfaction scores. This project should also have a secondary outcome of increasing physician satisfaction scores as it would raise the quality of life for physicians by enabling them to spend more time with their own families and clinic patients instead of having to round on their patients at the hospital.

<u>Related Category 3 Outcome Measures:</u>

OD-6 Patient Satisfaction
IT-6.1: Percent improvement over baseline of patient satisfaction scores
094109802.3.7

Reasons/rationale for selecting the outcome measures:

This project will result in improved patient satisfaction scores as a result of implementing a hospitalist program at LPDS. A hospitalist program will 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. Currently there is a shortage of primary care physicians in El Paso and this shortage is causing increased lengths of stay and decreased patient satisfaction. We expect a hospitalist model will improve patient satisfaction by reducing the wait times for treatment decisions, and will improve the documentation of patient's diagnoses, treatment and outcomes.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Together with LPDS's Primary Care Physician Recruitment project (094109802.1.1) and Expand Specialty Care Capacity project (094109802.2.2), this project will greatly improve the quality and efficiency of the inpatient experience at LPDS.

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

UMC El Paso, Tent Sierra Providence East Medical Center, and Providence Memorial Hospital have developed plans to implement projects that will also increase patient satisfaction at their facilities.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$4,615,429. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the logistical work required to change patterns of care in the inpatient setting, as well as the potential

for quality improvement and patient experience improvement resulting from a successfully implemented hospitalist program.

094109802.2.3	*2.4.3*	*2.4.3*	*EVALUATE HOSPITALIST MODEL*
HCA Las Palmas Del Sol			*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.7*	*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-7] Assess organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement.Metric 1: [P-7.1] Submission of an assessment that includes answering questions such as: Methods used to obtain experience data (e.g. mailed surveys vs. phone) ; Findings (e.g. scores as a whole, service line, locations) Baseline/Goal: We will submit an assessment addressing the questions in the DSRIP menu Data Source: Assessment Patient Impact – 0 patients have been impacted as the hospital is formulating the plan. Milestone 1 Estimated Incentive Payment: $1,128,770	**Milestone 2** [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 1 [P-11.1]: Submission of implementation plan. Baseline/Goal: Currently there is no implementation plan; we will submit one plan. Data Source: Implementation plans. Milestone 2 Estimated Incentive Payment: $1,231,428	**Milestone 3** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Baseline/Goal: Increase number of organization-wide displays by 2 displays over DY 2 baseline. Data Source: Display and internal communication Patient Impact – Total Patients encounters over DY2 baseline is 14,125 Milestone 3 Estimated Incentive Payment: $1,235,007	**Milestone 4** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Baseline/Goal: Increase number of organization-wide displays by 3 displays over DY 2 baseline. Data Source: Display and internal communication Patient Impact – Total Patients encounters over DY2 baseline is 14,972 Milestone 4 Estimated Incentive Payment: $1,020,224
Year 2 Estimated Milestone Bundle Amount: $1,128,770	Year 3 Estimated Milestone Bundle Amount: $1,231,428	Year 4 Estimated Milestone Bundle Amount: $1,235,007	Year 5 Estimated Milestone Bundle Amount: $1,020,224

094109802.2.3	***2.4.3***	***2.4.3***	***EVALUATE HOSPITALIST MODEL***	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.7*	*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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,615,429				

95788

Project Option 2.2.2: Apply evidence-based care management model to patients identified as having high-risk health care needs: **CONGESTIVE HEART FAILURE CLINIC**

Unique Project ID: 094109802.2.4

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Summary of Project:

Provider: Las Palmas Del Sol is a 655 licensed bed hospital system in El Paso, Texas serving a 250 square-mile area and a metropolitan population of approximately 820,000.

Intervention(s): This project will establish a Clinical Information System (registry) to structure, organize, and trend patient data for registries, performance measurements, and prevention services. Along with this registry, this initiative will enable collaboration with area home-health agencies to prevent readmissions. Finally, this program will commit to the education and training of healthcare professionals within the CHF healthcare delivery system.

Need for the project: El Paso has a population that is approximately 80 percent Hispanic. Two of the leading chronic diseases afflicting Hispanics are heart disease and diabetes. In 2009, total U.S. Hispanic deaths related to Disease of heart accounted for 24.6 percent of all deaths (National Vital Statistics Report, October 2012). Managing heart disease, and other chronic illnesses, with a structured program and collaborative effort amongst the healthcare providers is vital for the region.

Target Population: The target population is the patient population that is suffering from chronic heart disease, most of which are patients over 65. These patients mostly present themselves in the ED, which generally serves about 65% Medicaid eligible and indigent patients. The patient mix for LPDS of Cardiology inpatients for Medicaid and Indigent is approximately 18 percent, and we expect that the population served by this project will reflect a similar percentage.

Category 1 or 2 Expected patient benefits: The project seeks to establish a registry for heart disease patients by DY2. . We don't expect to have any patient impact in DY2 and DY3 as a result of formulating the registry and implementing training. We plan to have 250 patients in the registry by DY3. We anticipate by DY4 that 1,200 patients will receive care under the Chronic Care Model and by DY5 2,100 patients will receive care under the Chronic Care Model in the registry by DY5.
Category 3 outcomes: IT-3.2 Our goal is to reduce the congestive heart failure 30-day readmission rate by 2.5% from DY3 in DY4, and 5% from DY3 in DY5.

Project Description:

We propose to implement a Chronic Care Management Model relating to patients with Congestive Heart Failure (CHF).

The Congestive Heart Failure Initiative will consist of a multi-disciplinary team of expert health professionals to deliver optimal patient care through the utilization of current evidence-based guidelines and the development and implementation of new initiatives to meet service delivery

gaps. The multi-disciplinary care team will be composed of physicians, physician extenders, educators, behavioral health professionals, pharmacological advisors, dieticians, nursing staff, and health care navigators. This initiative will also enable the hospital to collaborate with community-based home-health agencies whereby the home-health agencies will provide timely feedback to help the prevention of unnecessary readmissions. The model will also include a Clinical Information System (registry) to structure, organize, and trend patient data for registries, performance measurements, and prevention services. This registry we are considering is called CDEMS and is used by community health centers, primary care practices, rural clinics, hospitals, and quality improvement projects across the United States and in Canada, India, Haiti, and South Africa. This program was developed and is shared by the Washington Diabetes Prevention and Control Program. Using a registry that is widely utilized will better allow our organization to report on patient populations with chronic health conditions. Applications of self-management principles through patient-centered interventions will include education resources, skill training, tele-scales, and psychosocial support. By applying self-management principles, the support will empower and prepare patients to manage their health and healthcare. Finally, this program will commit to the education and training of healthcare professionals to include physicians, nurses, ancillary staff, and community-based partners; such training will provide awareness of the resources available.

Goals and Relationship to Regional Goals:

Project Goals: Utilizing current evidence-based guidelines to create hospital wide standard protocols/pathways for the prevention, detection and management of heart failure will result in healthier patients, decreased readmissions and cost savings. Delivering optimal patient care in line with current evidence-based guidelines to decrease complications and meet delivery gaps related to CHF due to lack of collaborative management and lack of understanding, by the patient. Promoting self-awareness and self-management with the result of improved outcomes and increased continuity of care. Developing a centralized approach to CHF management based upon clinical practice guidelines, which will result in improved overall health for the hypertensive patient.

This project meets the following regional goals: This project is tied to Region 15's goal of providing better management of patients with chronic diseases, such as Diabetes, CHF, Asthma, COPD, Epilepsy, Dementia, and Renal disease to help prevent unnecessary readmission and get patients the care they need to prevent, self-manage, and address in an appropriate setting. LPDS will accomplish this goal by tracking and managing diabetic patients through a registry database system. This project is also tied to Region 15's goal of addressing the issues of Diabetes and Obesity, as they represent major health concerns in Region 15.

Challenges:

It will be difficult to notify the public of this available resource. ED discharge and wrap-up of outpatient visits will be the best patient-care opportunities to notify patients with Congestive Heart Failure of this outpatient resource designed specifically for their needs.

5-Year Expected Outcome for Provider and Patients:

By more effectively managing chronic disease patients discharged from our facility, we expect to reduce inappropriate ED utilization. This project will also reduce costs to the overall healthcare delivery system and provide more self-management education to patients with chronic diseases.

Finally, we hope to increase the number of patients that are discharged to a community placement or organization.

Starting Point/Baseline:

Las Palmas Del Sol is using protocols designed by the American Heart Association "Get With the Guidelines" program and CMS core measures that allow for in-house concurrent reviews by Quality management personnel. There is no centralized program that brings these protocols together.

Rationale:

The leading cause of death in the United States among all ethnicities is heart disease; it is also a common cause of illness and disability. The principal form of heart disease is coronary heart disease (CHD), also called ischemic heart disease. It is caused by buildup of cholesterol deposits in the coronary arteries that feed the heart. In the U.S. there are about 1.1 million persons who have a heart attack or myocardial infarction every year. According to the Texas Department of Health, in 1999 the death rate in El Paso County due to heart disease was 203.5 per 100,000 population per year, compared to a rate of 272.7 per 100,000 population per year for Texas as a whole. While Hispanics have a CHD death rate that is less than that of the U.S. population as a whole, it is still the number one cause of death among Hispanics. The rate for CHD for the U.S. population as a whole is 216 per 100,000 population per year compared to 151 per 100,000 population per year for Hispanics.

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.

Project Components:

This project will accomplish the following project components:

- Apply evidence-based care management model to patients identified as having high-risk health care needs.
    - LPDS will apply the evidence-based Chronic Care Model to congestive heart failure patients.
- Conduct quality improvement for the project using methods such as rapid-cycle improvement.

- Following the implementation of the Chronic Care Model, LPDS will continue to improve the model and, ideally, further improve patient outcomes, by conducting quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

Currently, LPDS does not utilize a chronic disease database system that can be used to track CHF patients. Utilization of a registry will help care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventative care. LPDS is currently using protocols designed by the American Heart Association "Get With the Guidelines" program and CMS core measures that allows for in-house concurrent reviews. However, there is no database system that brings these protocols together.

Related Category 3 Outcome Measures:

OD-3 Potentially Preventable Readmissions—30-Day Readmission Rates

IT-3.2: Congestive Heart Failure 30-Day Readmission Rate

094109802.3.8

Reasons/rationale for selecting the outcome measures:

This project will help create hospital-wide standard protocols/pathways for the prevention, detection and management of heart failure and will result in healthier patients, decreased readmissions and cost savings. This project will also help promote self-awareness and self-management with the result of improved outcomes and increased continuity of care. Developing a centralized approach to CHF management based upon clinical practice guidelines will result in improved overall health for the hypertensive patient.

Relationship to Other Projects: This project is part of LPDS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, this project will complement LPDS's Diabetes Management Registry project (094109802.1.3); both of these projects are targeted towards patient populations for whom delivery system reform could result in great improvements in the cost and quality of care, as well as improvements in overall patient population health.

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

UMC El Paso, Tent Sierra Providence East Medical Center, and Providence Memorial Hospital have developed plans to implement projects that will also reduce preventable readmissions at their facilities.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$8,307,772. The valuation of each LPDS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the need for these services for this patient population (i.e., congestive heart failure patients), and the possibility of significant cost and quality improvement when the project is implemented.

094109802.2.4	*2.2.2*	*2.2.2*	*CONGESTIVE HEART FAILURE CLINIC*
HCA Las Palmas Del Sol			*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.8*	*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 [P-3]: Develop a comprehensive care management program. 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: Currently there is no care management program. Data Source: Program materials Baseline – We have identified 294 staff members that could benefit from the training. Currently there are 0 staff members trained. There are currently 0 patients receiving care under the Chronic Care Model. Milestone 1 Estimated Incentive Payment: $2,031,786	**Milestone 2** [P-2]: 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: We expect to train at-least 50 staff member over DY2 baseline Data Source: HR; training program materials. Milestone 2 Estimated Incentive Payment: $1,108,285 **Milestone 3 [P-3]**: Develop a comprehensive care management program. Metric 1 [P-3.2]: Increase the number of patients enrolled in a care management program over baseline. Baseline/Goal: Enroll 250 patients in program over DY2. Data Source: Program enrollment records Milestone 3 Estimated Incentive Payment: $1,108,285	**Milestone 4** [I-17]: Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally. Metric 1 [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC. Baseline/Goal: 1,200 patients receive care under the Chronic Care Model over DY3 Data Source: Registry. Milestone 4 Estimated Incentive Payment: $2,223,013	**Milestone 5** [I-17]: Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally. Metric 1 [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC. Baseline/Goal: 2,100 patients receive care under the Chronic Care Model over DY3 Data Source: Registry. Milestone 5 Estimated Incentive Payment: $1,836,402
Year 2 Estimated Milestone Bundle Amount: $2,031,786	Year 3 Estimated Milestone Bundle Amount: $2,216,570	Year 4 Estimated Milestone Bundle Amount: $2,223,013	Year 5 Estimated Milestone Bundle Amount: $1,836,402

094109802.2.4	*2.2.2*	*2.2.2*	*CONGESTIVE HEART FAILURE CLINIC*	
HCA Las Palmas Del Sol				*094109802*
Related Category 3 Outcome Measure(s):	*094109802.3.8*	*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)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,307,772				

95794

Project Option 2.12.2: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population: **IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS**

Unique Project ID: 130601104.2.1

Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 130601104

Project Summary:
Provider: Providence Memorial Hospital is a 508 bed, acute care facility in El Paso Texas. PMH provides pediatric services to the community and serves the community of El Paso, which has a population of about 665,000. HHSC has also designated Providence as a Major Safety Net Hospital in Region 15.

Intervention(s): This project will support and enhance discharge planning assessment and intervention, with the development of new tools to assist case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days.

Need for the project: Hospital Readmissions Report from the Six-Month Medicare Claims Data from Providence Memorial Hospital QIO reported a Readmission Rate of 17.85 (all cause) for 2011 to a target of 14.65%. Improvement must be made to identify and target those patients that are high risk for readmission. Currently, there is no process in place that targets these high risk patients.

Target population: The target population for this project are patients being discharged from our facility. Approximately 44% of our patients facility-wide are Medicaid eligible or indigent. As this project targets all discharges to identify those at risk of readmission, we expect that a similar percentage of Medicaid eligible and uninsured patients will benefit from the implementation of this project.

Category 1 or 2 expected patient benefits: Implementing a tool to assess patients who are at a high risk for readmission would allow PMH to provide this patient population with a comprehensive discharge/transition plan that will promote self-management of a chronic disease, and attainment of community resources to support the patient in the appropriate health setting or home and avoid preventable readmissions. We do not expect that any patients will benefit directly in DY2, as Providence will be implementing a standardized care transition process and developing a staffing and implementation plan to accomplish the project goals. In DY3, we expect that about 3,529 patient admissions will benefit, about 7,059 in DY4, and about 10,588 in DY5.

Category 3 outcomes: To achieve improvement under this metric, PMH will engage in project planning during DY 2. In DY 3, Sierra East will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, the intent is to improve all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, PMH intends to improve its all-cause 30-day readmission rate by at least % over the DY 3 measurement.

Project Description:

This project will provide discharge planning assessment and intervention for targeted patients with a high risk of readmission.

This project will involve identification and targeting of patients with the highest risk of readmission. This project will support and enhance discharge planning assessment and intervention, with the development of tools that assist case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days. The intent of this project is to improve the core discharge planning function and support a safe, effective, and efficient transition to post-acute care. The ultimate goal will be to reduce preventable readmissions by identifying and developing comprehensive discharge plans that meet the needs of the high-risk population early in the patient stay. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions.

Following the implementation of the project, quality improvement activities will be conducted to foster continued learning by staff regarding the most effective methods for ensuring quality care transitions. High-risk assessment will be integrated into an existing assessment, increasing the time a case manager must have with the patient/family, making implementation of the project somewhat challenging.

Goals and Relationship to Regional Goals:

Project Goals: The goal of such this project is to ensure that the hospital discharge is accomplished appropriately and that care transitions occur effectively and safely, as evidenced by identification and targeting of patients that are high risk for re-admission and development of a discharge plan based on the individualized patient needs. Through high-risk assessment at the point of admission, patients will be identified and targeted and interventions will promote an individualized, effective and safe transition. Transitions from inpatient care to the home setting will be supported and readmissions or revisits within 30 to 60 days will be reduced.

This project meets the following regional goals: Implementing a tool to assess patients who are at a high risk for readmission, would allow PMH to provide this patient population with a comprehensive discharge/transition plan that will promote self-management of a chronic disease, and attainment of community resources to support the patient in the appropriate health setting or home and avoid preventable readmissions. This project would support the Regional goal of improvement management of patients with chronic diseases and the goal of prevention of unnecessary readmissions. The project would support the goal of getting patients the care they need to prevent, self-manage, and address in an appropriate setting; The comprehensive transition plan from these high risk screenings would facilitate the Regional goals of the provision of patient education to ensure the population is accessing the right care in the right setting, assist in removing barriers to accessing healthcare resources in the region; and Increase patient satisfaction through delivery of high-quality, effective healthcare services.

Challenges:

A major challenge facing the successful implementation of this project is the difficulty inherent in ensuring that patients properly follow discharge instructions.

5-Year Expected Outcome for Provider and Patients:

Providence expects timely identification and targeting of patients with the highest risk of readmission will support and enhance discharge planning assessment and intervention, with the development of tools that assist case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days. PMH expects the improvement of the core discharge planning function. The expectation then is to ultimately reduce preventable readmissions by identifying and developing comprehensive discharge plans that meet the needs of the high-risk population early in the patient stay. PMH believes that a comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions.

Starting Point/Baseline:

Evaluation of readmissions tied to identified diagnostic groups will provide the baseline data to determine the starting point for case management training.

Rationale:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings.

Project Components:

This project will accomplish the following project components:

a) Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.
    - Providence will improve the core discharge planning function and support a safe, effective, and efficient transition to post-acute care.

b) Conduct quality improvement for the project using methods such as rapid-cycle improvement. 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.
    - Providence will continue to improve its discharge planning interventions by conducting quality improvement activities following the implementation of the interventions.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

Implementing a tool to assess patients who are at a high risk for readmission, would allow PMH to provide this patient population with a comprehensive discharge/transition plan that will promote self-management of a chronic disease, and attainment of community resources to support the patient in the appropriate health setting or home and avoid preventable readmissions. This will enhance the current discharge planning process.

Related Category 3 Outcome Measures:

OD-3 Potentially Preventable Re-Admissions—30-Day Readmission Rates (PPRs)
IT-3.1: All-cause 30-day readmission rate
130601104.3.4

Reasons/rationale for selecting the outcome measures:

Providence anticipates that the enhanced discharge interventions for high-risk patients will create a more effective post-discharge health management strategy. Through increased focus on these high-risk patients, Providence hopes to more effectively match high-risk patients with community resources and non-hospital based service venues to seek follow-up care. Providence will partner with local community organizations and non-profits to attempt to address the ongoing healthcare needs of those with a high-risk of readmission. Providence hopes that these additional efforts will reduce the potentially, preventable readmissions rate at its facility, because these "frequent flyers" will have information and access to non-acute healthcare settings.

Relationship to Other Projects: This project is part of Providence's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Providence's Expand Primary Care Access project (130601104.1.1) and Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2); each of these projects is intended to improve the patient experience by providing care in more effective and efficient ways.

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

This project complements Sierra Providence East Medical Center's similar care transitions project.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will

continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$6,717,071. In determining the value of this project, Tenet considered the extent to which newly-implemented or expanded care transitions programs will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this project takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this project also takes into account the challenges that Providence will face in implementing this project in the hospital setting.

Tenet plans to implement a similar Category 2 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.2.1	*2.12.2*	*2.12.2*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
Providence Memorial Hospital				*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.4*	*IT-3.1*	***All cause 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]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transitions policies and procedures. Baseline/Goal: Currently there is no care transition procedure in place that focuses on high-risk patients. There are about 7,600 patients admitted per year. Data Source: Policies and procedures of care transitions program materials. Milestone 1 Estimated Incentive Payment: $821,378 **Milestone 2:** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transition program. Metric 1 [P-7.1]: Documentation of the staffing plan. Baseline/Goal: Currently there is no care transition procedure in place that focuses on high-risk patients. There are about 17,650 patients admitted per year. Data Source: Staffing and implementation plan.	**Milestone 3** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: Our goal is to reach 20% of admitted patients. Data Source: Registry or EHR report/analysis. Patient impact: about 3,529 patient admissions. Milestone 3 Estimated Incentive Payment: $1,792,160		**Milestone 4** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: Our goal is to reach 40% of admitted patients. Data Source: Registry or EHR report/analysis. Patient impact: about 7,059 patient admissions. Milestone 4 Estimated Incentive Payment: $1,797,370	**Milestone 5** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: Our goal is to reach 60% of admits. Data Source: Registry or EHR report/analysis. Patient impact: about 10,588 patient admissions. Milestone 5 Estimated Incentive Payment: $1,484,784

130601104.2.1	***2.12.2***	***2.12.2***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Providence Memorial Hospital				*130601104*
Related Category 3 Outcome Measure(s):	*130601104.3.4*	*IT-3.1*	***All cause 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 2 Estimated Incentive Payment: $821,379				
Year 2 Estimated Milestone Bundle Amount: $1,642,757	Year 3 Estimated Milestone Bundle Amount: $1,792,160		Year 4 Estimated Milestone Bundle Amount: $1,797,370	Year 5 Estimated Milestone Bundle Amount: $1,484,784
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,717,071				

93835

Project Option 2.12.2: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population: **IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS**

Unique Project ID: 196829901.2.1

Performing Provider Name/TPI: Sierra Providence East Medical Center / TPI: 196829901

Project Summary:

Provider: Sierra Providence East Medical Center (Sierra East) is a 110 bed, acute care facility in Far East El Paso Texas. Its primary service area serves a population of approximately 331,000 over 5 contiguous zip codes.

Intervention(s): This project will support and enhance discharge planning assessment and intervention, with the development of tools that assist case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days.

Need for the project: Hospital Readmissions Report from the Six-Month Medicare Claims Data from Sierra East QIO reported a Readmission Rate of 19 % (all cause) for 2011 to a target of 15%. Improvement must be made to identify and target those patients that are high risk for readmission. Currently, there is no process in place that targets these high risk patients.

Target population: The target population for this project includes patients being discharged from Sierra East. Approximately 36% of our patients facility-wide are Medicaid eligible or indigent. As this project targets all discharges to identify those at risk of readmission, we expect that a similar percentage of Medicaid eligible and uninsured patients will benefit from the implementation of this project.

Category 1 or 2 expected patient benefits: Implementing a new tool to assess patients who are at a high risk for readmission will allow Sierra East to provide this patient population with a comprehensive discharge/transition plan that will promote self-management of chronic diseases and help patients attain community resources to support the patient in the appropriate health setting or home and avoid preventable readmissions. One of the overarching goals of the Transformation Waiver is to provide the right care in the right setting – this project will aide discharged patients in obtaining much-needed care in a non-emergent venue. We do not expect that any patients will benefit directly in DY2, as Sierra East will be implementing a standardized care transition process and developing a staffing and implementation plan to accomplish the project goals. In DY3, we expect that about 1,521 patient admissions will benefit, about 3,023 in DY4, and about 4,564 in DY5.

Category 3 outcomes: To achieve improvement under this measure, Sierra East will engage in project planning during DY 2. In DY 3, Sierra East will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, the intent is to improve all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, Sierra East intends to improve its all-cause 30-day readmission rate by at least % over the DY 3 measurement.

Project Description:

This project will provide discharge planning assessment and intervention for targeted patients with a high risk of readmission.

This project will involve identification and targeting of patients with the highest risk of readmission. This project will support and enhance discharge planning assessment and intervention, with the development of tools that assist case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days. The intent of this project is to improve the core discharge planning function and support a safe, effective, and efficient transition to post-acute care. The ultimate goal will be to reduce preventable readmissions by identifying and developing comprehensive discharge plans that meet the needs of the high-risk population early in the patient stay. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions.

Following the implementation of the project, quality improvement activities will be conducted to foster continued learning by staff regarding the most effective methods for ensuring quality care transitions. High-risk assessment will be integrated into an existing assessment, increasing the time a case manager must have with the patient/family, making implementation of the project somewhat challenging.

Goals and Relationship to Regional Goals:

Project Goals: The goal of such this project is to ensure that the hospital discharge is accomplished appropriately and that care transitions occur effectively and safely, as evidenced by identification and targeting of patients that are high risk for re-admission and development of a discharge plan based on the individualized patient needs. Through high-risk assessment at the point of admission, patients will be identified and targeted and interventions will promote an individualized, effective and safe transition. Transitions from inpatient care to the home setting will be supported and readmissions or revisits within 30 to 60 days will be reduced.

This project meets the following regional goals: Implementing a tool to assess patients who are at a high risk for readmission, would allow Sierra East to provide this patient population with a comprehensive discharge/transition plan that will promote self-management of a chronic disease, and attainment of community resources to support the patient in the appropriate health setting or home and avoid preventable readmissions. This project would support the Regional goal of improvement management of patients with chronic diseases and the goal of prevention of unnecessary readmissions. The project would support the goal of getting patients the care they need to prevent, self-manage, and address in an appropriate setting; The comprehensive transition plan from these high risk screenings would facilitate the Regional goals of the provision of patient education to ensure the population is accessing the right care in the right setting, assist in removing barriers to accessing healthcare resources in the region; and Increase patient satisfaction through delivery of high-quality, effective healthcare services.

Challenges:

A major challenge facing the successful implementation of this project is the difficulty inherent in ensuring that patients properly follow discharge instructions. Sierra East hopes

5-Year Expected Outcome for Provider and Patients:

Sierra Providence East expects timely identification and targeting of patients with the highest risk of readmission will support and enhance discharge planning assessment and intervention, with the development of tools that assist case managers to identify and target those patients at risk for readmission to the hospital within 30 to 60 days. Sierra East expects the improvement of the core discharge planning function. The expectation then is to ultimately reduce preventable readmissions by identifying and developing comprehensive discharge plans that meet the needs of the high-risk population early in the patient stay. Sierra East believes that a comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions.

Starting Point/Baseline:

Evaluation of readmissions tied to identified diagnostic groups will provide the baseline data to determine the starting point for case management training.

Rationale:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings.

Project Components:

This project will accomplish the following project components:

a) Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.
    - Sierra East will improve the core discharge planning function and support a safe, effective, and efficient transition to post-acute care.

b) Conduct quality improvement for the project using methods such as rapid-cycle improvement. 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.
    - Sierra East will continue to improve its discharge planning interventions by conducting quality improvement activities following the implementation of the interventions.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

Implementing a tool to assess patients who are at a high risk for readmission, would allow Sierra East to provide this patient population with a comprehensive discharge/transition plan that will promote self-management of a chronic disease, and attainment of community resources to support the patient in the appropriate health setting or home and avoid preventable readmissions. This will enhance the current discharge planning process.

Related Category 3 Outcome Measures:

OD-3 Potentially Preventable Re-Admissions—30-Day Readmission Rates (PPRs)
IT-3.1: All-cause 30-day readmission rate
196829901.3.4

Reasons/rationale for selecting the outcome measures:

Sierra East anticipates that the enhanced discharge interventions for high-risk patients will create a more effective post-discharge health management strategy. Through increased focus on these high-risk patients, Sierra East hopes to more effectively match high-risk patients with community resources and non-hospital based service venues to seek follow-up care. Sierra East will partner with local community organizations and non-profits to attempt to address the ongoing healthcare needs of those with a high-risk of readmission. Sierra East hopes that these additional efforts will reduce the potentially, preventable readmissions rate at its facility, because these "frequent flyers" will have information and access to non-acute healthcare settings.

Relationship to Other Projects: This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the El Paso community, while improving access to care and containing the costs of care. Specifically, this project will complement Tenet's Expand Primary Care Access project (196829901.1.1) and Enhance Interpretation Services and Culturally Competent Care project (196829901.1.2); each of these projects is intended to improve the patient experience by providing care in more effective and efficient ways.

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

This project complements Providence Memorial Hospital's similar care transitions project.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and

minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$3,771,290. In determining the value of this project, Tenet considered the extent to which newly-implemented or expanded care transitions programs will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this project takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this project also takes into account the challenges that Sierra East will face in implementing this project in the hospital setting.

Tenet plans to implement a similar Category 2 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196829901.2.1	*2.12.2*	*2.12.2*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
Sierra Providence East Medical Center				*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.4*	*IT-3.1*	***All cause 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]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transitions policies and procedures. Baseline/Goal: Currently there is no care transition procedure in place that focuses on high-risk patients. There are about 7,600 patients admitted per year. Data Source: Policies and procedures of care transitions program materials. Milestone 1 Estimated Incentive Payment: $461,162 **Milestone 2:** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transition program. Metric 1 [P-7.1]: Documentation of the staffing plan. Baseline/Goal: Currently there is no care transition procedure in place that focuses on high-risk patients. There are about 7,600 patients admitted per year. Data Source: Staffing and implementation plan. Milestone 2 Estimated Incentive Payment: $461,162	**Milestone 3** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: Our goal is to reach 20% of admitted patients. Data Source: Registry or EHR report/analysis. Patient impact: about 1521 patient admissions. Milestone 3 Estimated Incentive Payment: $1,006,206	**Milestone 4** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: Our goal is to reach 40% of admitted patients. Data Source: Registry or EHR report/analysis. Patient impact: about 3043 patient admissions. Milestone 4 Estimated Incentive Payment: $1,009,131	**Milestone 5** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: Our goal is to reach 60% of admits. Data Source: Registry or EHR report/analysis. Patient impact: about 4564 patient admissions. Milestone 5 Estimated Incentive Payment: $833,630

196829901.2.1	***2.12.2***	***2.12.2***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Sierra Providence East Medical Center				*196829901*
Related Category 3 Outcome Measure(s):	*196829901.3.4*	*IT-3.1*	***All cause 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)**
Year 2 Estimated Milestone Bundle Amount: $922,324	Year 3 Estimated Milestone Bundle Amount: $1,006,206		Year 4 Estimated Milestone Bundle Amount: $1,009,131	Year 5 Estimated Milestone Bundle Amount: $833,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,771,290				

93812

Project Option 2.1.3: The Development of a Primary Care Medical Home in a Health Professions Shortage Area.

Unique Project ID: 084597603.2.1

RHP Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Provider: The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the Performing Provider's outpatient setting, approximately 60% of our patient visits were provided to patients with Medicaid or who were uninsured. We are the single largest provider of ambulatory services to these groups in Region 15. The cost of the uncompensated care we will provide in DY2 is an estimated $11,600,000.

Interventions: This project will complete the infrastructure development, provider recruitment, system redesign and training required to allow the Kenworthy Family Medicine Clinic to achieve level 1 NCQA designation as a medical home.

Need for the project: Region 15 is profoundly underserved in primary care providers with an estimated shortage of over 360 providers, yet the region's population has a rate of diabetes and obesity above the national average based on the 2010 BRFSS survey. Given these shortages, access for patients with Medicaid or no funding is exceptionally challenging. The benefits of the medical home model are well documented in the medical literature, and are reflected in the Category 1 and 3 improvement milestones we have selected.

Target Population:
a) Number of patients served: DY2 will be a year of planning, including criteria for assignment to a medical home, appropriate panel size and software selection and training. Assignment of patients to the medical home will begin in DY3. We estimate roster of unique patients will be assigned to the medical home at the end of each year will be:

DY2:0 DY3:750 DY4:1000 DY5: 1250
b) Benefit to Medicaid / Indigent Patients: Given that 60% of our enterprise ambulatory encounters are to patients with Medicaid or no insurance, this project will be a direct benefit to that population.

Category 1 or 2 expected benefits : The alternative communication strategies and registry structure required of a medical home will directly benefit the clinic population. In addition, the clinic will focus on HEDIS screening standards for mammograms, and by DY 5, 75% of eligible patients assigned to the Primary Care Medical Home will have received a screening mammogram or have documentation of declining the screening.

Category 3 outcomes: The Category 3 outcomes target optimal care for patients with diabetes including diabetic foot exams, screening for diabetic nephropathy / microalbumenemia and retinal eye exams . Each of these milestones will be at 65% compliance OR a 10% increase from the baseline rate established in DY3.

This project represents a significant expansion of the efforts the Kenworthy Family Medicine Clinic has made to date to becoming accredited as a primary care medical home. As noted above, they have undertaken a series of steps within existing resources to begin the process. To complete the process

requires adding infrastructure and non-physician providers to formalize the concept of a "team". In addition, it requires the infrastructure support to develop methodologies to track relevant clinical metrics and to develop and implement alternative communication strategies.

Project Description:

The purpose of this project is to establish the Department of Family Medicine Kenworthy Clinic as a Primary Care Medical Home. By doing so, we will improve overall chronic disease management and promote health outcomes in the target population.

Project Goal: The goal of this project is to develop the Department of Family Medicine Kenworthy Clinic as a Patient Centered Medical Home (PCMH) model of care delivery, offering improved chronic disease management and health promotion outcomes, and expanded access and training to family medicine residents in the delivery of care in the PCMH setting. This will enable our trainees to implement the concepts of a PCMH in border and underserved settings upon graduation. We will use evidence based change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative.

The Department of Family Medicine fully embraces the concept of the medical home and is eager to complete the process. Up to this point, the primary challenge has been the funding resources to recruit the non-physician providers to the team; a particular challenge given our high proportion of indigent and Medicaid patients.

We have chosen improvement targets which focus on the care of patients with diabetes. One of these, annual eye exams, will be particularly challenging to meet given the profound shortage of ocular care professionals in the Region.

From the patient perspective, the challenge will be to help patients understand the concept of the medical home, and understand how to fully utilize the benefits such a model provides to them. As we complete the process milestones in DY2, patient education will be a significant part of the roll-out. Likewise, Process metric-13 will include patient educational planning to address this need.

Goals and Relationship to Regional Goals: A number of providers in our region are proposing efforts to increase access to primary care and utilize the primary care medical home model. Even with these regional efforts, primary care will be seriously under-manned in our Region.

5-year expected outcome for patients and providers; the Family Medicine Clinic at Kenworthy will be accredited by the NCQA as a PCMH, fully integrating non physician and physician providers into care teams, and will be fully utilizing a disease management registry to manage populations of patients at risk. Patients will have access to a team based approach to their care, and identify Kenworthy as their medical home.

Challenges: The major challenge in completing the designation as a medical home has been related to costs of building the infrastructure of provider and non-provider personnel required, as well as the necessary administrative support to manage the endeavor.

Baseline: We have already taken initial organizational steps based on the standards of a Patient Centered Medical Home in order to deliver culturally sensitive, coordinated, integrated, and

comprehensive care with improved access and including high quality care from a personal physician and practice team. We have already implemented advanced access scheduling including a well-established open access model that allocates 30% of appointments each day to same day request and we have a modern EMR that meets meaningful use criteria and supports evidence based protocols. The Family Medicine Clinic is a self-contained, 24,000 sq. ft. clinic that offers a full spectrum of adult and pediatric acute and chronic care.

Rationale:

Primary care in RHP 15 is in a state of crisis. In 2010, the Paso del Norte Foundation sponsored a region wide planning symposium addressing and documenting health care needs in a broad area which includes Region 15. This survey documented that Texas counties comprising Region 15 have profound needs in primary care providers. Using nationally recognized benchmark data, the survey estimated the **Region needed three hundred and sixty four Family Medicine, General Internal Medicine or General Practice Providers** (1)**.** This situation will worsen as more patients are insured under the Affordable Care Act (2).

The Family Medicine Clinic at Kenworthy represents an ideal model to create a PCMH. The clinic is a self-contained, 24,000 sq. ft. facility that offers a full spectrum of adult and pediatric acute and chronic care. It is located in a Health Professions Shortage Area for both primary care and mental health care. Our population suffers from a disproportionate burden of chronic diseases. The BRFSS 2010 self-reported rate of overweight and obesity, risk factors for diabetes, in PHA Region 9/10 is 67.5 %, while the nationwide rate is 64.3. Over 70% of El Paso residents are of Hispanic ethnicity, an additional risk factor for diabetes. Therefore, most of the population is at risk for diabetes. Indeed, the self-reported rate of diabetes in El Paso is 12.8%, compared to a nationwide self-reported rate of 9.3%. This becomes even more significant as the population ages. The self-reported rate of diabetes in El Paso increases from 6.4 % when less than 45 years of age to 19.1 % for ages 45 to 64 and to 28.5% for ages 65 and older. The overall impact of this particular chronic disease is huge, and 37.1% of BRFSS respondents from El Paso report no health insurance, compared to a nationwide rate of 15.1%.

The population served by PLFSOM is particularly at risk. The Performing Provider is the single largest multi-specialty provider group in the Region, representing more than 250 providers, and the largest provider of primary and specialty care within the Region, providing approximately 223,000 outpatient visits a year. In the current fiscal year to date, approximately 60% of the performing provider's ambulatory visits have been provided to patients with Medicaid or no insurance. Given the profound shortage of primary care providers, it is very difficult for unfunded or underfunded patients to access primary care for chronic conditions, and simply not realistic to assume that a medical home model will evolve spontaneously in such an under-served market.

As we have developed EMR capabilities, and worked with managed care providers to look at HEDIS quality measures, we see that there are significant opportunities to improve the care of patients with diseases common in the Region. For example, looking at 2011 date from one of our managed Medicare providers, we note that roughly half of our patients had an eye exam or HbA1c testing in the past year. We believe that completing the transition to an accredited Patient Centered Medical Home will be a significant step toward improving such metrics.

Project Components: we chose project option 2.1.3. As particularly relevant to our population and Kenworthy's location in a HPSA. We will complete all components of this project option:

a) Empanelment: Assign all patients to a primary care provider within the medical home. The steps necessary to achieve this are part of the process milestones in DY2. In DY3, we will complete the actual assignment of patients to medical teams.

b) Restructure staffing into multidisciplinary care. This is accomplished in Milestone 1 in DY2.

c) Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care. This will be accomplished as part of Process metric P-7 in DY3

d) Assure that patients are able to see their provider or care team whenever possible. As part of the process of reorganizing into care teams, we will develop training for schedulers to be able to identify the patient's medical team and schedule appropriately.

e) 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. Our organization is already committed to establishing a patient portal linking providers, our EMR and patients. As part of this initiative, medical home patients will have access to secure email communication as well as existing phone and in-person visits.

f) Conduct quality improvement for project using methods such as rapid cycle improvement. We will incorporate this element by including status of the PCMH as a standing agenda item on the weekly Department meeting.

The next steps in completing our transition to a patient centered medical home are to 1) expand the advanced access services by developing the Infrastructure (clinical staff, providers and administrative staff) to offer evening and weekend clinics to our patient population, and we will implement e-visits, group visits and home visits as well. The expanded access will enable patients to access their practice and providers at times more suitable for them and their families and reduce visits to urgent care facilities and emergency rooms where often unnecessary care and tests are conducted; 2) Develop a multidisciplinary team approach to improve patient care for those with chronic diseases. We will utilize professionals from other disciplines working alongside providers in managing chronic diseases inside and outside of the traditional practice setting. We will integrate community nurses, dieticians and pharmacists into practice teams with physicians and mid-level providers to optimize chronic disease management and assist in the care of patients recently discharged from hospital, as well as for non-compliant patients in a culturally sensitive manner. The pharmacist will advise on polypharmacy issues and be able to assist with our elderly and chronic disease afflicted population to reduce drug interactions and optimize existing medication regimes; 3) Develop innovative approaches to Health Promotion and Screening: A navigator will use the patient registry to identify and track patients through the health promotion and screening program. We will integrate community health (Outreach) workers, dieticians and nurses with physicians and mid-level providers into practice teams to optimize health promotion, health screening and disease prevention educational sessions within communities in a culturally sensitive manner; and 4) We will train our family medicine residents on the principles of the PCMH so that they are skilled in working in a PCMH setting. Since most West Texas medical residents stay within a 75 mile radius of their training site to set up practice (3), and greater than 80% of our graduating family medicine residents choose to serve in medically underserved areas (including RHP 15), our residents will be trained to replicate this model in these communities upon graduation.

The milestones proposed for this project build from the current state of readiness of the clinic to establish a PCMH, and reflect the remaining process steps necessary to complete this transition. These include reorganizing the staff into teams, defining the criteria to be enrolled in a PCMH, enhancing communication options between providers and patients, and implementing a recall system to demonstrate the ability to identify populations of patients who would benefit from additional services. The improvement targets include obtaining a nationally recognized accreditation as a PCMH, and to improve screening rates for two conditions which significantly impact our population, namely eye disease in diabetes and breast cancer.

As the single largest multi-specialty provider group in the Region, and the largest provider of primary and specialty care within the Region, PFLSOM provides nearly 250,000 outpatient visits a year. The development of Patient Centered Medical Home within the Paul L. Foster School of Medicine Department of Family Medicine represents the best opportunity to integrate care management, primary care and necessary consultative services through a single provider referral network and EMR to meet well documented needs of our unfunded and underfunded patient base.

Community Need: This project addresses community need CN.1 Primary Care and CN. 3

How the project represents a new initiative or a significant expansion of an existing healthcare delivery system reform: This project represents a significant expansion of the efforts the Kenworthy Family Medicine Clinic has made to date to becoming accredited as a primary care medical home. As noted above, they have undertaken a series of steps within existing resources to begin the process. To complete the process requires adding infrastructure and non-physician providers to formalize the concept of a "team". In addition, it requires the infrastructure support to develop methodologies to track relevant clinical metrics and to develop and implement alternative communication strategies.

Category 3 Related Outcomes:
IT-1.12 Diabetes care: Retinal eye exam—NQF 0055 (Non- standalone measure)
IT-1.13 Diabetes care Foot exam- NQF 0056 (Non- standalone measure)
IT-1.14 Diabetes care: *Microalbumin/Nephropathy NQF 0062 (Non- standalone measure)*

Relationship to Other Projects and Measures: This project is closely linked with other projects we are proposing:

1) 084597603.1.2 - The establishment of a disease management registry within the Paul L. Foster School of Medicine. This project will initially focus on diabetes in the Department of Family Medicine, and subsequently, the Department of Internal Medicine. Diabetes represents a high impact disease in our population, and coordinating resources to this condition is critical to success.

2) 084597603.1.1 - Expansion of Specialty Care in Ophthalmology: As defined more completely in that project narrative, we have a critical shortage of Ocular care professionals caring for high risk patients. We can document poor compliance with recommended screening examinations. Impacting this issue will require a data registry, expansion of ocular care professionals and tracking and recall efforts as proposed in this project.

Relationship to Other Providers' Projects in the RHP: A number of providers in the Region are offering proposals to enhance primary care access in the region, and UMC is proposing to establish medical homes in their primary care clinics as well.

Plan for Learning Collaborative: The performing provider will participate in semi-annual learning collaboratives within the RHP addressing access issues and the expansion of medical homes.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

References:

1. Paso del Norte Blue Ribbon Committee for a Strategic Health Framework. Phase One: Needs Assessment Report. March 24, 2011. On File.

2. Supply Trends Among Licensed Health Professions, Texas 1980-2009. Texas Department of State Health Services.

3. Texas Tech University Health Sciences Center Factbook. Sixteenth ed December 2008.

084597603.2.1	*2.1.3*	***PROJECT COMPONENTS 2.1.3 (A-F)***	The Development of a Primary Care Medical Home in a Health Professions Shortage Area.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.12 084597603.3.13 084597603.3.14	IT-1.12 IT-1.13 IT-1.14	Diabetes care: Retinal eye exam Diabetes care Foot exam Diabetes care: Microalbumin/Nephropathy

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] Reorganize staff into primary care teams responsible for the coordination of patient care. Metric 1 [P-3.1] Patient Care Teams. Baseline/Goal: 80% of clinical staff will be reorganized into patient care teams. Data Source: Staff Assignment Documentation Milestone 1 Estimated Incentive Payment (*maximum amount)*: $225,000 **Milestone 2** :[P-5] Determine the appropriate panel size[22] for primary care provider teams Metric 1 [P-5.1] Determine Panel Size Baseline/Goal: The Clinic will develop, disseminate and implement policies regarding the determination and monitoring of panel sizes. Data Source: EMR, Policy Documentation Milestone 2 Estimated Incentive Payment (*maximum amount)*: $225,000	**Milestone 5** [P-10]: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric 1 [P-10.1]: Documentation of interaction types and which patients would most benefit from particular interaction types. Baseline/Goal: The Department will develop , disseminate and implement policies to provide Group visits for patients with Diabetes Data Source: Scheduling System Milestone 5 Estimated Incentive Payment: $206,493 **Milestone 6** [P-11]: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population Metric 1 [P-11.1]: Implement a patient registry that captures preventive services utilization.	**Milestone 10** [P-11]: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population Metric 1 [P-11.2]: Implement a recall system Baseline/Goal: The Department will establish a recall system to identify and notify patients assigned to a Medical Home who have a diagnosis of diabetes and have not received an eye examination as recommended by the current HEDIS guidelines Data Source: Recall Report Milestone 10 Estimated Incentive Payment: $276,124.50 **Milestone 11** :[P-13] Review Project Date and respond to it every week. Metric 1 [P-13.1] Number of new ideas, practices, tools, or solutions tested by each provider Baseline/Goal: The Clinic will establish a reoccurring agenda item in their weekly all Staff Department Meeting in which improvements to the PCMH model	**Milestone** 14:[P-13] Review Project Date and respond to it every week. Metric 1 [P-13.1] Number of new ideas, practices, tools, or solutions tested by each provider Baseline/Goal: The Clinic will establish a reoccurring agenda item in their weekly all Staff Department Meeting in which improvements to the PCMH model are proposed, discussed and documented Data Source: Quarterly summary of ideas presented at these meetings Milestone 14 Estimated Incentive Payment (*maximum amount)*: 355,716 **Milestone** 15[1-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 1 [I-17.1]: Goal: Reminders for patient preventive services Goal: 75% of patients assigned to a

22 Measure panel size by the number of patients assigned to a provider care team, by provider FTE. For part-time providers or residents who are assigned a dedicated panel, list the true panel size with percentage FTE. Panel size analysis could support panel management decisions as clinics approach population management.

084597603.2.1	*2.1.3*	***PROJECT COMPONENTS 2.1.3 (A-F)***	The Development of a Primary Care Medical Home in a Health Professions Shortage Area.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.12 084597603.3.13 084597603.3.14	IT-1.12 IT-1.13 IT-1.14	Diabetes care: Retinal eye exam Diabetes care Foot exam Diabetes care: Microalbumin/Nephropathy

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 3 :[P-6] Establish criteria for medical home assignment Metric 1 [P-6.1] Establish Medical Home Assignment Criteria Baseline/Goal: The Clinic will develop , disseminate and implement policies criteria to assign patients to a medical home Data Source: EMR, Policy Documentation Milestone 3 Estimated Incentive Payment (*maximum amount)*: $225,000 **Milestone 4** :[P-13] Review Project Date and respond to it every week. Metric 1 [P-13.1] Number of new ideas, practices, tools, or solutions tested by each provider Baseline/Goal: The Clinic will establish a reoccurring agenda item in their weekly all Staff Department Meeting in which improvements to the PCMH model are proposed, discussed and documented Data Source: Quarterly summary of ideas presented at these meetings	Baseline/Goal: The Department will establish a recall system to identify and notify patients assigned to a Medical Home who have not received screening mammography as recommended by the current HEDIS guidelines Data Source: Recall Report Milestone 6 Estimated Incentive Payment: $206,493 **Milestone 7**:[P-13] Review Project Date and respond to it every week. Metric 1 [P-13.1] Number of new ideas, practices, tools, or solutions tested by each provider Baseline/Goal: The Clinic will establish a reoccurring agenda item in their weekly all Staff Department Meeting in which improvements to the PCMH model are proposed, discussed and documented Data Source: Quarterly summary of ideas presented at these meetings Milestone 7 Estimated Incentive Payment (*maximum amount)*: $206,493	are proposed, discussed and documented Data Source: Quarterly summary of ideas presented at these meetings Milestone 11 Estimated Incentive Payment (*maximum amount)*: $$276,124.50 **Milestone 12** [1-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 1 [I-17.1]: Reminders for patient preventive services Goal: 60% of patients assigned to a PCMH meeting the HEDIS criteria for receiving a screening mammogram will have received one OR the medical record will document that the patient declined this screening OR the medical record will have documented an attempt to contact patient to inform them of screening recommendation. Examination. Data Source: EMR, registry records	PCMH meeting the HEDIS criteria for receiving a screening mammogram will have received one OR the medical record will document that the patient declined this screening OR the medical record will have documented an attempt to contact patient to inform them of screening recommendation. Examination. Data Source: EMR, registry records Milestone 15Estimated Incentive Payment: 355,716 Milestone 16 [I-12]: Improve the number of eligible patients assigned to the medical home Metric 1 [I-12.1]:Number or percent of eligible patients assigned to a medical home Goal: 1250unique patients will be assigned to the medical home Data Source: tracking report showing assignment and panel status Milestone 16Estimated Incentive Payment $355,716

084597603.2.1	*2.1.3*	***PROJECT COMPONENTS 2.1.3 (A-F)***	The Development of a Primary Care Medical Home in a Health Professions Shortage Area.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.12 084597603.3.13 084597603.3.14	IT-1.12 IT-1.13 IT-1.14	Diabetes care: Retinal eye exam Diabetes care Foot exam Diabetes care: Microalbumin/Nephropathy

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 4 Estimated Incentive Payment (*maximum amount*): $225,000	**Milestone 8** [I-X]: Obtain medical home recognition by a nationally recognized agency. Metric 1 [I-.1]: Obtain Medical Home accreditation. Goal: The Family Medicine Program at Kenworthy will achieve recognition by NCQA as a Level One Medical Home Data Source: Documentation of accreditation status from NCQA Milestone 8 Estimated Incentive Payment: $206,493 **Milestone 9 [P-7]:** Track the assignment of patients to the designated care team Metric 1 [P-7.1]: Tracking medical home patients Baseline/Goal: The baseline is zero patients assigned to a medical home. By the end of DY3, we will have assigned a minimum of 750 unique patients to the medical home model. Data Source: tracking report showing assignment and panel status Milestone 9 Estimated Incentive Payment: $206,493	Milestone 12 Estimated Incentive Payment: $276,124.50 Milestone 13 [I-12]: Improve the number of eligible patients assigned to the medical home Metric 1 [I-12.1]:Number or percent of eligible patients assigned to a medical home Goal: 1000 unique patients will be assigned to the medical home Data Source: tracking report showing assignment and panel status Milestone 13 Estimated Incentive Payment: $276,124.50	
Year 2 Estimated Milestone Bundle	Year 3 Estimated Milestone Bundle	Year 4 Estimated Milestone Bundle	Year 5 Estimated Milestone Bundle

084597603.2.1	*2.1.3*	***PROJECT COMPONENTS 2.1.3 (A-F)***	The Development of a Primary Care Medical Home in a Health Professions Shortage Area.
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 3 Outcome Measure(s):	084597603.3.12 084597603.3.13 084597603.3.14	IT-1.12 IT-1.13 IT-1.14	Diabetes care: Retinal eye exam Diabetes care Foot exam Diabetes care: Microalbumin/Nephropathy

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)**
Amount: $900,000	Amount: $1,032,465	Amount: $1,104,498	Amount: $1,067,148
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $4,104,111			

95701

Project Option 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

Unique Project ID: ***127376505.2.1***
Performing Provider Name/TPI: Emergence Health Network/127376505

Provider: Emergence Health Network (EHN), formerly known as the EI Paso Mental Health & Mental Retardation (MHMR), was established as the Local Mental Health Authority pursuant to Chapter 534 of the Texas Health & Safety Code. EHN maintains 24 locations in EI Paso County and provides a comprehensive array of services, designed for both adults and children. Individuals are involved in treatment plan development, assessment and in full spectrum of mental health services such as psychiatric, case management, crisis hotline, consumer peer support psychosocial rehabilitation and therapy and substance abuse. EHN operates with a well trained team of 450 staff--providers, management, clinical and non-clinical support staff.

Intervention: In 2011, the *Regional Strategic Health Framework Needs Assessment Report* produced by the Paso Del Norte Health Foundation identified the need to address "inappropriate holding of individuals with mental health needs in local emergency rooms." The current behavioral health care system in El Paso County has limited options for appropriate community based services and a shortage in acute/sub-acute inpatient beds. This results in individuals receiving treatment in local emergency departments, the criminal justice system and other systems of care. Emergence Health Network (EHN), the local mental health authority for El Paso County, proposes to develop a Crisis Respite Unit ("CRU") as an alternative to inappropriate systems of care for an estimated 1,459 individuals presenting in a psychiatric crisis over a four year period. The Crisis Respite Unit is a diversionary service that presently does not exist in El Paso County. The concept model involves short-term and crisis oriented intervention techniques common to half-way houses. As a stabilization and treatment alternative, the CRU will reduce the utilization of emergency departments and criminal justice systems by providing residential treatment of a full range of acute problems for individuals in a "home like" non-hospital setting. The proposed scope of work of this new initiative involves short term respite care (hourly or 24-hours), home like settings, individual and group skills training, activities of daily living skills, and medication self-management education.

Target population: The target population for this project is individuals who are at risk of psychiatric crises due to a housing challenge and/or severe stressors in the family, but are at low risk of harm to self or others.

Category 1 or 2 expected patient benefits: With implementation of the CRU, the expected outcome is a reduction in the utilization of the local emergency rooms, jails and state hospitals for treatment. The expected patient benefit is that individuals will have access to behavioral health care in the most appropriate setting.

Category 3 outcomes: The goal is to reduce inappropriate utilization of local emergency departments.

Scope of Project: This is a new initiative.

Project Description:
Emergence Health Network ("EHN") proposes to develop a Crisis Respite Unit ("CRU") as an alternative to inappropriate systems of care.

Crisis respite treatment involves hourly or 24-hour care that is usually short-term and offered to individuals who are at risk of psychiatric crises due to a housing challenge and/or severe stressors in the family, but are at low risk of harm to self or others. Crisis respite units create a normalized environment (e.g., apartments, group and foster homes, and the individual's own home). During facility-based respite, individual and group skills training are provided and are based on the needs of the individual and the goals of their individual crisis plans. Individuals are able to perform their own activities of daily living. With staff supervision, individuals shall be able to self-administer medication. Individuals should have enough medications upon arrival to ensure psychiatric and medical stabilization for the expected length of stay. The primary objective of crisis respite services is stabilization and resolution of a crisis situation for the individual and/or the individual's caregiver(s).

The current behavioral health care system in El Paso, TX has limited options for appropriate community based services and a shortage in acute/sub-acute inpatient beds. This results in individuals receiving treatment in local emergency departments, the criminal justice system and other systems of care. When individuals are treated in less desirable settings, the cost to the community significantly increases

Goals and Relationship to Regional Goals:

The goal of this project is to provide an additional choice for appropriate behavioral health crisis resolution. In addition, the CRU will alleviate the burden currently placed on local emergency departments and first responders. EHN believes that early intervention and access to behavioral health services decreases the utilization of inappropriate systems of care

When services are provided in appropriate settings the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Project Goals:

- Increase access to appropriate behavioral health services
- Decrease utilization of inappropriate systems of care.
- Decrease the overall volume of individuals utilizing hospital emergency departments for psychiatric care.

This project meets the following regional goals:

- Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care.

EHN believes that early intervention and access to behavioral health services decreases the utilization of inappropriate systems of care. When services are provided in appropriate settings, such as a CRU, the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Challenges:

The primary challenge for this project will be to engage treating physicians, law enforcement, and other community stakeholders to utilize the CRU as an appropriate community based service for individuals with behavioral health needs. EHN will overcome this challenge by providing educational meetings to community stakeholders. EHN will collaborate with community stakeholders to develop and implement processes related to the CRU.

5-Year Expected Outcome for Provider and Patients:

Emergence Health Network expects to see a reduction in the number of emergency room visits utilized by individuals presenting in a psychiatric crisis. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline: The CRU is a new initiative for the community, therefore EHN estimates to serve 365 individuals in year 3; 469 in year 4; and 625 in year 5. Total individuals expected to be served under this project is 1,459.

Rationale:

The CRU will assist the El Paso Community by diverting individuals away from the local Emergency Departments and law enforcement contact to a more appropriate treatment setting. Utilization of the CRU will result in an overall cost savings for the community. The goal of the CRU is to:

- Avoid an impending crisis due to housing challenges or other identified stressors in the family.
- Provide short-term assistance to caregivers of the consumer to minimize the need for a more restrictive service setting.
- Provide the consumer with appropriate supervision and assistance in a non-stressful environment
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

"Inappropriate holding of individuals with mental health needs in local emergency rooms" *(Regional Strategic Health Framework Needs Assessment Report 2011)* was identified as an area requiring improvement. It was identified that individuals with mental health needs are in local emergency rooms for up to 172 hours awaiting appropriate services. On a monthly basis there is an average of approximately 374 individuals waiting in an emergency department for behavioral health care. Of those 374 individuals and average of 164 are admitted into an inpatient psychiatric facility. In addition, on a monthly basis there is an average of 300 individuals in the El Paso County Detention Facility identified with behavioral health needs. Implementation of this proposed project will provide an additional choice for appropriate behavioral health crisis resolution, alleviate the burden currently placed on local emergency departments and first responders and be an avenue for law enforcement to divert individuals in crisis to more appropriate settings.

Project Components:

Through the CRU, EHN proposes to meet the following project components:

a) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement. EHN will conduct an assessment of the target population. The written plan will include current utilization patterns, eligibility criteria for each service array.

c) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* On a monthly basis, EHN will monitor impact on access and quality of services through data collection.

e) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* On a monthly basis, EHN will monitor impact on access and quality of services through data collection. Key community stakeholders will participate in the meetings to assist in identifying "lessons learned" and implementation of interventions as challenges are identified. EHN is the designated Mental Health Authority therefore will serve as the community safety-net.

EHN has chosen not to implement the following project components:

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. EHN has chosen to implement a CRU as the service model for this project.

d) Design models which include an appropriate range of community-based services and residential supports. EHN has chosen to implement a CRU as the service model for this project.

Unique community need identification numbers the project addresses:

- CN.3 – Behavioral Health

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

Currently, a CRU does not exist in El Paso County. The initiative will improve access to appropriate community based behavioral health care.

No other federal funding is being utilized for this initiative.

<u>Related Category 3 Outcome Measures:</u>

OD-9 Right Care, Right Setting:
IT 9.2 ED appropriate utilization

- Reduce Emergency Department visits for target conditions
  - Behavioral Health/Substance Abuse

Reasons/rationale for selecting the outcome measures:

The expected outcome is that there will be a reduction in the utilization of emergency departments and criminal justice system as individuals will receive the needed care in the CRU. EHN selected the outcome measures to address "inappropriate holding of individuals with mental health needs in local emergency rooms" *(Regional Strategic Health Framework Needs Assessment Report 2011).*

The concept of the Crisis Respite Unit is modeled from the techniques that were implemented in the development of half-way houses. These techniques are typically seen in short-term and crisis oriented settings. The program will offer services to individuals in a "home like" non-hospital setting/atmosphere. In a study titled, *Crisis Residential Treatment: Alternative to Hospitalization,* authors (Fields& Weisman, 1995) stated in their conclusion regarding their research on a program named La Posada, "Acute diversion programs such as La Posada, along with other levels of CR services, have become central elements of community crisis response systems. This level of care has moved far beyond the original model of the halfway house to incorporate a philosophy and practice of residential treatment that expands the ability of community-based programs to serve a full range of acute problems without requiring hospitalization."

Relationship to other Projects: The CRU project is related to the Extended Observation Unit (Project #1.1), Crisis Stabilization for IDD population (Project #2.2) and Expand Behavioral Health Providers (Project #1.2). The proposed projects offer additional crisis stabilization alternatives on the crisis continuum of care. The Expand Behavioral Health Providers project will ensure access to appropriate care in community settings.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: No other providers in the RHP are establishing a CRU. EHN will participate in bi-weekly meetings with other providers in the RHP to promote collaborative learning around shared, similar projects, or other projects impacting the community.

Project Valuation: EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals with a behavioral health diagnosis. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments, law enforcement, and other systems of care. It has been demonstrated that the utilization of psychiatric emergency services is cost effective and is a best practice in addressing behavioral health needs of individuals presenting in crisis. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

127376505 2.1	*2.13.1*	*2.13.1.A.C.E*	***CRISIS RESPITE UNIT***
Emergence Health Network			***127376505***
Related Category 3 Outcome Measure(s):	*IT-9.2*	*127376505 3.4*	OD-9 Right Care, Right Setting 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 1 (P-1.1): Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization. Baseline/Goal: Identify community needs Data Source: Project documentation; Inpatient, discharge and ED records; State psychiatric facility records; survey of stakeholders (inpatient providers, mental health providers, social services and forensics); literature review Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,077,697 **Milestone 2** (P-2) Design community-based specialized interventions for target populations.	**Milestone 3** (P-4) Evaluate and continuously improve interventions. Metric 1 (P-4.1): Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Baseline/Goal: Evaluate and improve services. Data Source: Project reports Milestone 3: Estimated Incentive Payment *(maximum amount):* $1,546,832 **Milestone 4** (I-5): Functional Status Metric 1 (I-5.1): The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) Goal: 20% of individuals served in DY3(54 individuals) Data Source: Standardized functional	**Milestone 6** (I-5): Functional Status Metric 1 (I-5.1): The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) Goal: 20% of individuals served in DY4 (93 individuals) Data Source: Standardized functional assessment (e.g. ANSA, CANS, etc.) Milestone 6 Estimated Incentive Payment: $2,248,253 **Milestone 7** (I-X): Utilization of appropriate crisis alternatives Metric 1 (I-X.1):% increase in utilization of appropriate crisis alternatives. Goal: EHN expects to serve 469 individuals (28% increase from DY2 in utilization of appropriate crisis alternatives) Data Source: Claims, encounter, and clinical record data.	**Milestone 8** (I-5): Functional Status Metric 1 (I-5.1): The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) Goal: 20% of individuals served in DY5 (125 individuals) Data Source: Standardized functional assessment (e.g. ANSA, CANS, etc.) Milestone 8 Estimated Incentive Payment: $1,617,302 **Milestone 9** (I-X): Utilization of appropriate crisis alternatives Metric 1 (I-X.1):% increase in utilization of appropriate crisis alternatives. Goal: EHN expects to serve 625 individuals (71% increase from DY2 in utilization of appropriate crisis alternatives) Data Source: Claims, encounter, and clinical record data.

127376505 2.1	***2.13.1***	***2.13.1.A.C.E***	***CRISIS RESPITE UNIT***	
Emergence Health Network				***127376505***
Related Category 3 Outcome Measure(s):	*IT-9.2*	*127376505 3.4*	OD-9 Right Care, Right Setting 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)**
Metric 1 (P-2.1): Project plans which are based on evidence / experience and which address the project goals. Baseline/Goal: Design community-based specialized interventions for target populations. Data Source: Project documentation Milestone 2: Estimated Incentive Payment *(maximum amount):* $2,077,697	assessment (e.g. ANSA, CANS, etc.) Milestone 4 Estimated Incentive Payment: $1,546,832 **Milestone 5** (I-X): Utilization of appropriate crisis alternatives Metric 1 (I-X.1):% increase in utilization of appropriate crisis alternatives. Goal: EHN expects to serve 365 individuals (8% increase in utilization of appropriate crisis alternatives) Data Source: Claims, encounter, and clinical record data. Milestone 5 Estimated Incentive Payment: $1,546,832		Milestone 7 Estimated Incentive Payment: $2,248,253	Milestone 9 Estimated Incentive Payment: $1,617,303
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,155,394	Year 3 Estimated Milestone Bundle Amount: $4,640,495		Year 4 Estimated Milestone Bundle Amount: $4,496,506	Year 5 Estimated Milestone Bundle Amount: $3,234,605
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $16,527,000				

Project Option 2.13.2 – Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative matter not described in the project options above.

Unique Project ID: 127376505 2.2 Pass 2
Performing Provider Name/TPI: Emergence Health Network/127376505

Project Summary

Provider: Emergence Health Network (EHN), formerly known as the EI Paso Mental Health & Mental Retardation (MHMR), was established as the Local Mental Health Authority pursuant to Chapter 534 of the Texas Health & Safety Code. EHN maintains 24 locations in EI Paso County and provides a comprehensive array of services, designed for both adults and children. Individuals are involved in treatment plan development, assessment and in full spectrum of mental health services such as psychiatric, case management, crisis hotline, consumer peer support psychosocial rehabilitation and therapy and substance abuse. EHN operates with a well-trained team of 450 staff--providers, management, clinical and non-clinical support staff.

Intervention: The current behavioral health care system in El Paso, TX has limited treatment intervention options for the targeted population. This project will expand the knowledge base of behavioral health care providers in the community.

Target population: The target population for this project is individuals with behavioral health needs. With additional therapeutic tools and interventions available to practitioners, the anticipated outcome is that there will be an improvement in the clinical outcomes of individuals with behavioral health needs. Our goal is to train Licensed Practitioners, EHN staff and community stakeholders in the Evidence Based Practices (EBP).

Category 1 or 2 expected patient benefits: With implementation of EBPs the expected outcome is a reduction in the utilization of the local emergency rooms, jails and state hospitals for treatment. The expected patient benefit is improved functional status among participants.

Category 3 outcomes: The goal is to demonstrate improved quality of life.

Scope of Project: This is a new initiative.

Project Description:
Emergence Health Network ("EHN") proposes to expand behavioral health/substance abuse training for the workforce.

Implementation of evidence-based trainings will include Dialectical Behavioral Therapy (DBT), Cognitive Processing Therapy (CPT), and "Recovery Innovations" curriculum. EHN believes implementing these trainings/curriculums will result in improved patient outcomes.

Goals and Relationship to Regional Goals:
The goal of this project is to expand behavioral health/ substance abuse training for Licensed Practitioners, EHN staff and community stakeholders. The current behavioral health care system in El Paso, TX has limited treatment intervention options for the targeted population.

Project Goals:

- Appropriate treatment modality for behavioral health needs
- Increased access to appropriate behavioral health services
- Decreased utilization of inappropriate systems of care

This project meets the following regional goals:

- Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care.

EHN believes that early intervention and access appropriate treatment modalities for behavioral health services decreases the utilization of inappropriate systems of care. When appropriate treatment modalities are provided in appropriate settings the cost for services significantly decreases and cost-savings is realized for all stakeholders.

Challenges:
The primary challenge for this project will be to engage local qualified clinicians to provide the treatment modalities. El Paso, Texas as a border region has a limited supply of licensed professional counselors. In addition, the "Recovery Innovations" curriculum is peer focused and identifying qualified peer providers poses a challenge to successful implementation.

5-Year Expected Outcome for Provider and Patients:
EHN expects to see improvements in quality of life and customer satisfaction through implementation of this project. In addition, expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
EHN will identify a starting baseline following completion of the community needs assessment.

Rationale:

Expansion of behavioral health/substance abuse training for the workforce will assist the El Paso Community by providing early intervention and access to appropriate treatment modalities for behavioral health services, which will decrease the utilization of inappropriate systems of care. "In a randomized control trial to evaluate the efficacy of Dialectical Behavior Therapy (DBT), Linehan et al. (1991) randomized women with severe borderline personality disorder (BPD) and a recent history of parasuicidal behavior, into one year of DBT. The DBT clients showed a reduction in the frequency and medical severity of parasuicide behaviors in the first four months and after one year of treatment, a reduction in the number of in-patient bed days, and increased retention in treatment. In addition, reductions in anger and improvements in social functioning were shown (Linehan, Tutek, Heard, & Armstrong, 1994). There is evidence that many of these improvements were maintained at 6 and 12 month follow up (Linehan, Heard, &Armstrong,

1993), with most notably a sustained improvement on the Global Assessment Scale and a continued reduction in in-patient bed use." *(Dialectical behavior therapy: An increasing evidence base, Janet Feigenbaum)*

Project Components / Project Option (2.13.2):

Through this proposed project, EHN proposes to meet the following project components:

a) *Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.* EHN will conduct a needs assessment for the target population.

b) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* On a monthly basis, EHN will monitor impact on access and quality of services through data collection. Key community stakeholders will participate in the meetings to assist in identifying "lessons learned" and implementation of interventions as challenges are identified. EHN is the designated Mental Health/IDD Authority therefore will serve as the community safety-net.

Unique community need identification numbers the project addresses:

- CN.3 – Behavioral Health

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

The current behavioral health care system in El Paso, TX has limited treatment intervention options for the targeted population. Expanding treatment modalities will improve access to appropriate community based behavioral health care.

No other federal funding is being utilized for this initiative.

<u>Related Category 3 Outcome Measure(s):</u>
OD-10 Quality of Life/Functional Status
IT- 10.1 Quality of Life

Reasons/rationale for selecting the outcome measures:
The anticipated outcome for the selected project is that there will be demonstrated improvement in individuals' clinical outcomes. Therefore, EHN chose OD-10/IT-10.1 as an outcome measure to improve symptoms and functioning.

Relationship to other Projects: This project is related to the Extended Observation Unit (EOU) (Project #1.1) and Expand Behavioral Health Providers (Project #1.2). Individuals referred to the EOU will benefit from expanded treatment modalities related to this project. In addition, it is the intent of Project #1.2 to increase the number of psychiatrists and licensed behavioral health providers in order to expand capacity and access in the El Paso community and ensure access to appropriate care in community settings.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: No other providers in the RHP are implementing projects related to expansion of behavioral health providers however there are several projects related to expansion of specialty care. EHN will participate in scheduled meetings with other providers in the RHP to promote collaborative learning around shared, similar projects, or other projects impacting the community.

Project Valuation: Valuation of the EOU was based on average cost and length of stay related to individuals that require inpatient hospitalization, individuals served by local emergency departments, and individuals incarcerated.

127376505 2.2 PASS 2	***2.13.2***	***2.13.2***	***EVIDENCE-BASED PRACTICES***
Emergence Health Network			***127376505***
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127376505.3.5Pass2*	OD-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-1) Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 1 (P-1.1): Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization. Baseline/Goal: Identify trainings to be implement based on need Data Source: Project documentation; Inpatient, discharge and ED records; State psychiatric facility records; survey of stakeholders; literature review Milestone 1 Estimated Incentive Payment *(maximum amount):* $184,616	**Milestone 2** (P-2) Design community-based specialized interventions for target populations. Interventions may include specialized behavioral therapies, psychosocial rehabilitation, and peer support. Metric 1 (P-2.1): % increase in the provision of specialized interventions. Goal: TBD Data Source: Claims, encounter, and clinical record data Milestone 2: Estimated Incentive Payment (maximum amount): $107,000.50 **Milestone 3** (P-4) Evaluate and continuously improve interventions. Metric 1 (P-4.1): Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Goal: TBD	**Milestone 4** (I-5): Functional Status Metric 1 (I-5.1): The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANs, etc.) Goal: TBD Data Source: Standardized functional assessment instruments (e.g. ANSA, CANS, etc.) Milestone 4 Estimated Incentive Payment: $228,914	**Milestone 5** (I-5): Functional Status Metric 1 (I-5.1): The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANs, etc.) Goal: TBD Data Source: Standardized functional assessment instruments (e.g. ANSA, CANS, etc.) Milestone 5 Estimated Incentive Payment: $221,175

127376505 2.2 PASS 2	***2.13.2***	***2.13.2***	***EVIDENCE-BASED PRACTICES***
Emergence Health Network			***127376505***
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127376505.3.5Pass2*	OD-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: Project Reports Milestone 3: Estimated Incentive Payment (maximum amount): $107,000.50		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $184,616	Year 3 Estimated Milestone Bundle Amount: $214,001	Year 4 Estimated Milestone Bundle Amount: $228,914	Year 5 Estimated Milestone Bundle Amount: $221,175
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $848,706			

Project Option 2.4.3 -- Redesign to improve Patient Experience: Creation of a Pediatric Hospitalist Program

Unique Project ID: 2981854201.2.1 Pass 2
Performing Provider Name/TPI: El Paso Children's Hospital / 2981854201

Project Description:

Provider:
El Paso Children's Hospital (EPCH) is a separately licensed pediatric inpatient facility located in El Paso, Texas. It has 122-beds, and the only dedicated pediatric hospital for over 200 miles. EPCH is a brand new hospital, which opened its doors on February 14, 2012. It is accredited by the Joint Commission.

Intervention:
Under this project, El Paso Children's Hospital will design, and implement a pediatric hospitalist model to increase productivity and access to care for patients, involving primary pediatric community physicians. The impact of this intervention is reflected by the patient care experience. By having a consistent team of Hospitalist providing care (while patients are inpatients in the hospital setting), families should be better informed while the care provided is more efficient. In addition, hospital employees increase their understanding of how our families perceive care and how best to improve how that care is given. Through being aware of patient survey outcomes, and identifying trends in care, employees can then address opportunities on how care can be modified at the point of service.

Need for the project:
Pediatric hospitalist services have been established across the country with a surge of programs from 2005 to present. Currently, there is a shortage of primary care pediatricians in El Paso and statewide that is causing lack of access to care. The pediatrician to child ratio demonstrates that this region is greatly underserved.

Area	Ratio
US Average	1 to 1769
Texas Average	1 to 2421
El Paso Average	1 to 3532

One of the major community benefits to pediatric hospitalist coverage is removing the burden from community pediatricians from having to round in hospitals allowing them to increase their productivity in their outpatient primary care setting, therefore improving access to care for children. Every patient day covered by a Hospitalist approximately equal one hour of extra time for community pediatricians to spend at their clinic (where they can see three additional patients, within that hour). Pediatric hospitalists seldom if ever cover their direct salaries and benefits but provide overall operational efficiencies, improved quality of care and increased inpatient referrals resulting in positive bottom lines for the program as a whole. There have been demonstrated results including: decreased average length of stay (ALOS), decreased readmissions, improved efficiency in patient discharge/admission, decreased adverse events, reduced cost per case and improved patient/referring satisfaction. The pediatric hospitalist

programs in settings including pediatric residents provide for improved supervision of the residents as well as advanced opportunities for education. The number one driver of the changes is the physical presence of a pediatrician at all times to oversee the patient's direct care (24/7), and having a provider available to talk to the parent of the pediatric patient.

Target population:

The target population are the pediatric patients in this region of 200 miles, and the community pediatricians that serve them. With the availability of a pediatric hospitalist program, community pediatricians will increase their capacity to care for patients in their medical offices, while the hospitalists can manage any inpatient stay.

Category 2 expected patient benefit:

This program will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients' diagnoses, treatment, and outcomes. The model should also improve the quality of life for community pediatricians, as they would no longer have to be on call or round in the middle of the night, and finally allow them additional capacity to serve the community, and not being distracted by inpatient care. During the first year, we anticipate the Hospitalist team will manage 80% of inpatient volume for general pediatrics. This equals to 1731 admissions or 5166 patient days per year. With an anticipated growth of 3 % of pediatric volume per year, and an increase of 3% of Hospitalist coverage, this program would increase pediatric coverage at the following rate:

- Baseline (DY2) = 1731 admissions or 5166 patient days per year
- DY 3= 1783 total admissions or 5321 patient days per year
- DY 4 = 1837 total admissions or 5481 patient days per year
- DY 5 = 1892 total admissions or 5645 patient days per year

For every patient day a hospitalist cares for an inpatient, equates to one hour of time for community pediatricians to see three patients per hour in their medical clinics. The additional number of patients impacted in the community would be as follows:

- Baseline (DY2): 5166 hours of increased capacity = 15499 patients seen in clinic setting
- DY3: 5321 hours of increased capacity = 15964 patients seen in clinic setting
- DY4: 5481 hours of increased capacity = 16443 patients seen in clinic setting
- DY 5: 5645 hours of increased capacity = 16936 patients seen in clinic setting

Scope:
This is an existing project that is relatively new, with 24/7 pediatric hospitalist coverage in place by October 1, 2012.

Goals and Relationship to Regional Goals:

Project Goals: Establish a full time, 24 hour/7day, pediatric hospitalist service for the El Paso Children's Hospital. With time, we expect the pediatric hospitalist service activity to increase

with community pediatricians utilizing the program (and therefore increasing patient satisfaction and patient outcomes).

This project meets the following regional goals: This project is tied to Region 15's goal of increasing patient satisfaction through the delivery of high-quality, effective healthcare services. By providing an in-house hospitalist program, patients will receive greater access to healthcare professionals and more timely care resulting in lower lengths of stay and a better patient experience.

Challenges:

Challenges include: high cost of providing the nurses and physicians; determining whether the hospitalist model will make a positive impact for patients; convincing primary care pediatricians that this model is better for their patients; accurately measuring the change in patient satisfaction; and creating additional capacity for inpatient beds.

5-Year Expected Outcome for Provider and Patients:

The creation of a pediatric hospitalist program will:

- reduce ALOS
- improve efficiency of patient admission/discharge including time in emergency department
- create capacity in primary care pediatrician offices as physicians use hospitalists, reduce time spent in hospitals and increase patient slots in their offices
- reduce cost of visits as hospitalists manage tests ordered.

The 5-year expected outcome of having a hospitalist program is to increase patient satisfaction scores. These scores provide an indication of the patient experience and also help EPCH address any deficiencies in a patient's care that might prevent the best healthcare delivery possible. Higher patient satisfaction means a high-quality and effective healthcare service that is being provided.

Starting Point/Baseline:

Currently, patients are admitted to their primary care pediatrician. Due to the shortage of primary care pediatricians, our physicians are over-burdened with their practice and often do not see patients in a timely manner. This causes delays in treatments which can lead to poor outcomes and increased lengths of stay.

- ALOS for General Pediatrics: 2.6 days
- Mean admission time from ED to Floor: 5hr 51 minutes (as care is delayed waiting for community physicians to free up time to come in and write orders).

Rationale:

Implemented hospitalist 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. Currently, there is a shortage of primary care pediatricians in El Paso and statewide that is causing lack of access to care. This lack of access is causing increased lengths of stay and decreased patient satisfaction. We expect that the move to a pediatric hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients' diagnoses, treatment, and outcomes. Hospitalists will manage the acute care of patients and expedite the care of patients within the hospital setting. Hospitalists will ensure patients' needs are met within a timely manner, because hospitalists are on duty 24 hours a day, they are fully available to patients from admission to discharge. This reduces complications, lengths of stay, and the costs of providing care. As noted, this model will relieve some primary care pediatricians from rounding in the hospital, thus enabling greater patient access to care as pediatricians will be able to spend more time in their practice.

Project Components / Project Option (2.4.3):

This project will accomplish the following project components:

j) Implement an innovative and evidence-based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area.
    - EPCH will improve patient satisfaction by implementing and evaluating a pediatric hospitalist model.

k) Conduct quality improvement for the project using methods such as rapid-cycle improvement.
    - Following the implementation of a pediatric hospitalist model, EPCH will continue to improve the model and, ideally, further improve patient satisfaction, by conducting quality improvement activities.

Unique community need identification numbers the project addresses:

- CN-1: Primary Care
- CN-2: Secondary and Specialty Care
- CN-6: Other Projects

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

El Paso Children's Hospital is a brand new facility in El Paso (February 14, 2012). Currently there is a pediatric hospitalist program at EPCH, with 24/7 coverage beginning October 1, 2012. This project would enhance service in patient outcomes, patient satisfaction, and should also have a secondary outcome of increasing physician satisfaction scores as it would raise the quality

of life for physicians by enabling them to spend more time with their own families and clinic patients instead of having to round on their patients at the hospital.

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:

This project will result in improved patient satisfaction scores as a result of implementing a hospitalist program at EPCH. A hospitalist program will 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. Currently there is a shortage of primary care physicians in El Paso and this shortage is causing increased lengths of stay and decreased patient satisfaction. We expect a hospitalist model will improve patient satisfaction by reducing the wait times for treatment decisions, and will improve the documentation of patient's diagnoses, treatment and outcomes.

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

UMC El Paso, Tenet Sierra Providence East Medical Center, and Providence Memorial Hospital have developed plans to implement projects that will also increase patient satisfaction at their facilities.

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15's community needs. UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

Project Valuation

$1,320,954. The valuation of the EPCH Category 2 project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the partial offset of costs required to change patterns of care in the inpatient setting, as well as the potential for quality improvement and patient experience improvement resulting from a successfully implemented hospitalist program. The time saved by community physicians in not rounding in a hospital setting, in turn increases pediatric population access to their services in the community.

2981854201.2.1PASS2	2.4	2.4.3	IMPLEMENT PEDIATRIC HOSPITALIST MODEL
El Paso Children's Hospital			TPI 2981854201
Related Category 3 Outcome Measure(s): OD-6	IT-6.1	2981854201.3.1 Pass 2	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 **Data Source:** Org Chart, job descriptions, hospitalist contracts, hospitalist schedules **Baseline:** 24/7 Hospitalist team (6) to benefit new hospital efficiency and improved patient care. Director of Family Support Services (under CNO) to direct the patient care experience. **DY2 Goal/Patient Benefit:** Hospitalist team will manage 80% of total general pediatric patients (1731 annual) increasing community pediatric potential to see an additional 15499 patients in their clinics. This will directly correlate to patient experience of getting timely medical care. Milestone 1 Estimated Incentive	**Milestone 2** [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 2** [P-11.1]: Submission of implementation plan. **Data Source:** Implementation plans. **Baseline:** Begin customer service staff meetings, posting on bulletin boards and inservices to all staff, annual evals reflecting customer service **DY3 Goal/Patient Benefit:** Hospitalist team will manage 83% of total general pediatric patients (1783 annual) increasing community pediatric potential to see an additional 15964 patients in their clinics. This will directly correlate to patient experience of getting timely medical care. **Milestone 2** Estimated Incentive	**Milestone 3: I-18** Develop regular organizational displays of patient and/or employee experience data (e.g. via dashboard on internal web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families **Metric 3: I-18.1** Number of organization wide displays (can be physical or virtual about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work **Data Source:** Leadership email or other communication to all staff regarding patient experience work; Intranet (internal) web dashboard**DY4 Goal:** In addition to DY3 baseline, add Web dashboard posting on Intranet, inservices to all staff, annual evals reflecting customer service **DY4 Goal/Patient Benefit:** Hospitalist team will manage 86% of total general pediatric patients (1837 annual) increasing community pediatric potential to see an additional 16443 patients in their clinics. This will directly correlate to patient experience	**Milestone 3: I-18** Develop regular organizational displays of patient and/or employee experience data (e.g. via dashboard on internal web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families **Metric 3: I-18.1** Number of organization wide displays (can be physical or virtual about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work **Data Source:** CEO email or other communication to all staff regarding patient experience work; web dashboard, patient care team documentation of iniatives**DY5 Goal:** In addition to DY4 Goal, development of patient care teams for each unit (NICU, PICU, General pediatrics, and Hemoncology) to focus on and lead hospital staff with customer service initiatives **DY5 Goal/Patient Benefit:** Hospitalist team will manage 89% of total general pediatric patients (1892 annual) increasing community pediatric potential to see an additional 16936 patients in their clinics. This will directly correlate to patient experience of getting timely medical care. **Milestone 4** Estimated Incentive Payment:

2981854201.2.1PASS2	2.4	2.4.3	IMPLEMENT PEDIATRIC HOSPITALIST MODEL
El Paso Children's Hospital			**TPI 2981854201**
Related Category 3 Outcome Measure(s): OD-6	**IT-6.1**	**2981854201.3.1 Pass 2**	**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)
payment: $341,467	payment: $349,254	of getting timely medical care. . **Milestone 3** Estimated Incentive payment: $348,684	$281,549
Year 2 Estimated Milestone Bundle Amount: $341,467	Year 3 Estimated Milestone Bundle Amount: $349,254	Year 4 Estimated Milestone Bundle Amount: $348,684	Year 5 Estimated Milestone Bundle Amount: $281,549
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,320,954			

Title of Outcome Measure (Improvement Target): IT-14.6: Primary Care Residency Training Program

Unique RHP outcome identification number(s): 138951211.3.1

Outcome Measure Description:
IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

- Rate 1: Percent of residency program trainees who have spent at least 5 years living in the El Paso County HPSA (138951211.1.1)

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 for rates 1 and 2. Survey 100 Residents

Outcome Improvement Targets for each year:

- DY4:
  - IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)—10% improvement over DY3 baseline
- DY5:
  - IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA) —20% improvement over DY3 baseline

Rationale:
UMC's Category 1 residency program and nurse residency program projects ("Expanded Residency Program" and "Establish Nurse Residency and Simulation Lab") are intended, in part, to leverage new or existing residency training programs in order to recruit more physicians and mid-level providers to underserved areas of the state, including El Paso. UMC believes that the successful implementation of these Category 1 projects will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 projects will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in these residency-related metrics will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while

containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 projects to address the community's need for more primary care and specialty care providers. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.1	*IT-14.6*	*Primary Care Residency Training Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.1*		
Starting Point/Baseline:	*Survey 100 Residents*		
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 project planning Process Milestone 1 Estimated Incentive Payment: $126,453	**Process Milestone 2** [P-2]: Establish baseline rates. Survey 100 Residents Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $146,576	**Outcome Improvement Target 1** [IT-14.6]: Percent of trainees who have spent at least 5 years living in an HPSA or MUA. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 1 Estimated Incentive Payment*:* $235,203	**Outcome Improvement Target 4** [IT-14.6]: Percent of trainees who have spent at least 5 years living in an HPSA or MUA. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 4 Estimated Incentive Payment*:* $562,441
Year 2 Estimated Outcome Amount: $126,453	Year 3 Estimated Outcome Amount: $146,576	Year 4 Estimated Outcome Amount: $235,203	Year 5 Estimated Outcome Amount: $562,441
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,070,673			

94981

Title of Outcome Measure (Improvement Target): IT-4.3: Catheter-Associated Urinary Tract Infection (CAUTI) Rates

Unique RHP outcome identification number(s): 138951211.3.2

Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Outcome Measure Description:
IT- 4.3: Catheter-Associated Urinary Tract Infection (CAUTI) Rates

- Rate 1: CAUTI rates (138951211.1.2)

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 for rate: 2011 Baseline Rates, Med-Surg ICU 7.9/1000.

Outcome Improvement Targets for each year:

- DY4:
    - IT-4.3: Catheter-Associated Urinary Tract Infection (CAUTI) Rates—3% improvement over DY3 = Med-Surg ICU 5.82/1000.
    -
- DY5:
    - IT-4.3: Catheter-Associated Urinary Tract Infection (CAUTI) Rates—3% improvement over DY4: Med-Surg ICU 5.65/1000.
    -

Rationale:
Through the implementation of the electronic systems described in the associated Category 1 project, real-time information will be captured which will alert process participants of increased potential for a Catheter-Associated Urinary Tract Infection (CAUTI) to develop. For example, leading indicators will alert the UMC Quality Management department when a particular patient possesses all the high risk indicators which contribute to the development of a CAUTI (e.g., dehydration, immobility, elderly, foley catheterization, etc.). Preventative measures can then be implemented to avoid the actualization of a CAUTI. Therefore, UMC believes that the successful implementation of the associated Category 1 project will result in a measurable improvement in CAUTI rates at UMC.

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in CAUTI rates at UMC will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 project to improve quality of care and thereby improve patient outcomes for the target

population. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.2	*IT-4.3*	*Catheter-Associated Urinary Tract Infection (CAUTI) Rates*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.2*		
Starting Point/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: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $239,595	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims; IQR/NHSN data. Process Milestone 2 Estimated Incentive Payment: *$*277,722	**Outcome Improvement Target 1** [IT-4.3]: Catheter-Associated Urinary Tract Infection (CAUTI) rates. Numerator: Number of cases of CAUTI as designated by IQR criteria. Improvement Target: 3% improvement over DY3. Data Source: EHR; claims; IQR/NHSN data. Annual patient impact 10,000 in DY4. Outcome Improvement Target 1 Estimated Incentive Payment*:* *$*445,647	**Outcome Improvement Target 2** [IT-4.3]: Catheter-Associated Urinary Tract Infection (CAUTI) rates. Numerator: Number of cases of CAUTI as designated by IQR criteria. Improvement Target: 3% improvement over DY4. Data Source: EHR; claims; IQR/NHSN data. Annual patient impact 11,000 in DY5. Outcome Improvement Target 2 Estimated Incentive Payment*:* *$*1,065,677
Year 2 Estimated Outcome Amount: $239,595	Year 3 Estimated Outcome Amount: *$*277,722	Year 4 Estimated Outcome Amount: *$*445,647	Year 5 Estimated Outcome Amount: *$*1,065,67
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,028,641			

95024

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 138951211.3.3

Outcome Measure Description:
IT- 6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

- Rate 1: Patient's rating of whether patient is getting timely care, appointments, and information (138951211.1.3)

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 for rates 1 through 3

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1: Patient's rating of whether patient is getting timely care, appointments, and information—TBD improvement over DY3
- DY5:
  - IT-6.1: Patient's rating of whether patient is getting timely care, appointments, and information—TBD improvement over DY4

Rationale:
UMC believes that the successful implementation of its three Patient Satisfaction-related Category 1 projects ("Establish More Primary Care Clinics UMC NHC –Crossroads"; "UMC Neighborhood Health Center East"; and "UMC Neighborhood Health Centers Ysleta and Fabens") will result in an improvement in patient satisfaction scores—specifically, an improvement of patients' ratings of whether they are receiving timely care, appointments, and information.

UMC proposes to utilize the GC/CHAPS Patient Satisfaction Survey to measure these patient satisfaction rates. UMC has gained experience with Press Ganey survey instruments within the past decade. Overall response rates for these survey instruments were very low—in the single-digit range. UMC believes there are a series of structural issues that drove this poor response rate. The population served by UMC includes a large number of low-income patients. Challenges

related to incorrect and changing addresses, and the comprehension level required to complete more complex survey tools such as Press Ganey (and CG-CAHPS) also limited the response rates for UMC's surveys. Also, UMC's Region shares an international border with Juarez, Mexico; many patients, whether documented or not, may fear responding to such a survey, not fully understanding the importance of their response, and not recognizing that their participation has no impact on their residence in the Region.

For these reasons, UMC believes that a short survey, administered at the point of service, represents the best option to obtain meaningful data across a wide patient representation. The RAND survey has been validated for accuracy and validity and contains questions which focus on high-level patient satisfaction domains and will provide actionable information to improve UMC's regional care delivery. UMC acknowledges that this survey will not provide results which are directly comparable to CG-CAHPS on a national level. The results of this survey will, however, provide valid, actionable data with which to assess the impact of the associated Category 1 projects in Region 15.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in patients' ability to get timely care, appointments, and information, measured from the patient perspective, will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of expanding primary care capacity at UMC's neighborhood health centers (NHCs) to improve quality of care and thereby improve patient outcomes for the target population. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.3	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.3*		
Starting Point/Baseline:	*TBD in DY2*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $379,359	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 2 Estimated Incentive Payment: $439,726	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Improvement Target: TBD improvement over DY3 in patient rating of whether patient is getting timely care, appointments, and information. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $705,608	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Improvement Target: TBD improvement over DY4 in patient rating of whether patient is getting timely care, appointments, and information. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $1,687,323
Year 2 Estimated Outcome Amount: $379,359	Year 3 Estimated Outcome Amount: $439,726	Year 4 Estimated Outcome Amount: $705,608	Year 5 Estimated Outcome Amount: $1,687,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,212,016			

95021

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 138951211.3.4

Outcome Measure Description:
IT- 6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

- Rate 1: Patient's rating of whether patient is getting timely care, appointments, and information (138951211.1.4)

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 for rates 1 through 3

Outcome Improvement Targets for each year:

- DY4:
    - IT-6.1: Patient's rating of whether patient is getting timely care, appointments, and information—TBD improvement over DY3
- DY5:
    - IT-6.1: Patient's rating of whether patient is getting timely care, appointments, and information—TBD improvement over DY4

Rationale:
UMC believes that the successful implementation of its three Patient Satisfaction-related Category 1 projects ("Establish More Primary Care Clinics UMC NHC –Crossroads"; "UMC Neighborhood Health Center East"; and "UMC Neighborhood Health Centers Ysleta and Fabens") will result in an improvement in patient satisfaction scores—specifically, an improvement of patients' ratings of whether they are receiving timely care, appointments, and information.

UMC proposes to utilize the GC/CHAPS Patient Satisfaction Survey to measure these patient satisfaction rates. UMC has gained experience with Press Ganey survey instruments within the past decade. Overall response rates for these survey instruments were very low—in the single-digit range. UMC believes there are a series of structural issues that drove this poor response rate. The population served by UMC includes a large number of low-income patients. Challenges related to incorrect and changing addresses, and the comprehension level required to complete more complex survey tools such as Press Ganey (and CG-CAHPS) also limited the response rates for UMC's surveys. Also, UMC's Region shares an international border with Juarez, Mexico; many patients, whether documented or not, may fear responding to such a

survey, not fully understanding the importance of their response, and not recognizing that their participation has no impact on their residence in the Region.

For these reasons, UMC believes that a short survey, administered at the point of service, represents the best option to obtain meaningful data across a wide patient representation. The RAND survey has been validated for accuracy and validity and contains questions which focus on high-level patient satisfaction domains and will provide actionable information to improve UMC's regional care delivery. UMC acknowledges that this survey will not provide results which are directly comparable to CG-CAHPS on a national level. The results of this survey will, however, provide valid, actionable data with which to assess the impact of the associated Category 1 projects in Region 15.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in patients' ability to get timely care, appointments, and information, measured from the patient perspective, will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of expanding primary care capacity at UMC's neighborhood health centers (NHCs) to improve quality of care and thereby improve patient outcomes for the target population. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.4	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.4*		
Starting Point/Baseline:	*TBD in DY2*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $379,359	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 2 Estimated Incentive Payment: $439,726	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Improvement Target: TBD improvement over DY3 in patient rating of whether patient is getting timely care, appointments, and information. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $705,608	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Improvement Target: TBD improvement over DY4 in patient rating of whether patient is getting timely care, appointments, and information. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $1,687,323
Year 2 Estimated Outcome Amount: $379,359	Year 3 Estimated Outcome Amount: $439,726	Year 4 Estimated Outcome Amount: $705,608	Year 5 Estimated Outcome Amount: $1,687,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,212,016			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 138951211.3.5

Outcome Measure Description:
IT- 6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

- Rate 3: Patient's rating of whether patient is getting timely care, appointments, and information (138951211.1.5)

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 for rates 1 through 3

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1: Patient's rating of whether patient is getting timely care, appointments, and information—TBD improvement over DY3
- DY5:
  - IT-6.1: Patient's rating of whether patient is getting timely care, appointments, and information—TBD improvement over DY4

Rationale:
UMC believes that the successful implementation of its three Patient Satisfaction-related Category 1 projects ("Establish More Primary Care Clinics UMC NHC –Crossroads"; "UMC Neighborhood Health Center East"; and "UMC Neighborhood Health Centers Ysleta and Fabens") will result in an improvement in patient satisfaction scores—specifically, an improvement of patients' ratings of whether they are receiving timely care, appointments, and information.

UMC proposes to utilize the CG/HCAPS Patient Satisfaction Survey to measure these patient satisfaction rates. UMC has gained experience with Press Ganey survey instruments within the past decade. Overall response rates for these survey instruments were very low—in the single-digit range. UMC believes there are a series of structural issues that drove this poor response rate. The population served by UMC includes a large number of low-income patients. Challenges

related to incorrect and changing addresses, and the comprehension level required to complete more complex survey tools such as Press Ganey (and CG-CAHPS) also limited the response rates for UMC's surveys. Also, UMC's Region shares an international border with Juarez, Mexico; many patients, whether documented or not, may fear responding to such a survey, not fully understanding the importance of their response, and not recognizing that their participation has no impact on their residence in the Region.

For these reasons, UMC believes that a short survey, administered at the point of service, represents the best option to obtain meaningful data across a wide patient representation. The RAND survey has been validated for accuracy and validity and contains questions which focus on high-level patient satisfaction domains and will provide actionable information to improve UMC's regional care delivery. UMC acknowledges that this survey will not provide results which are directly comparable to CG-CAHPS on a national level. The results of this survey will, however, provide valid, actionable data with which to assess the impact of the associated Category 1 projects in Region 15.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in patients' ability to get timely care, appointments, and information, measured from the patient perspective, will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of expanding primary care capacity at UMC's neighborhood health centers (NHCs) to improve quality of care and thereby improve patient outcomes for the target population. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.5	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.5*		
Starting Point/Baseline:	*TBD in DY2*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $319,460	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 2 Estimated Incentive Payment: $370,296	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Improvement Target: TBD improvement over DY3 in patient rating of whether patient is getting timely care, appointments, and information. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $594,196	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Improvement Target: TBD improvement over DY4 in patient rating of whether patient is getting timely care, appointments, and information. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $1,420,903
Year 2 Estimated Outcome Amount: $319,460	Year 3 Estimated Outcome Amount: $370,296	Year 4 Estimated Outcome Amount: $594,196	Year 5 Estimated Outcome Amount: $1,420,903
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,704,855			

Title of Outcome Measure (Improvement Target): IT-14.6: Nursing Residency Training Program

Unique RHP outcome identification number(s): 138951211.3.6

Outcome Measure Description:
IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

- Rate 1: Percent of nursing residency program trainees who have spent at least 5 years living in the El Paso County HPSA (138951211.1.6)

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 for rates 1 and 2. Baseline for DY3 is 15 Nurse Graduates to enter Nurse Residency Program. At the conclusion of the waiver, a total of 53 Nurse Graduates are to complete the Nurse Residency Program.

Outcome Improvement Targets for each year:

- DY4:
  - IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)—10% improvement over DY3 baseline
- DY5:
  - IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA) —20% improvement over DY3 baseline

Rationale:
UMC's Category 1 residency program and nurse residency program projects ("Expanded Residency Program" and "Establish Nurse Residency and Simulation Lab") are intended, in part, to leverage new or existing residency training programs in order to recruit more physicians and mid-level providers to underserved areas of the state, including El Paso. UMC believes that the successful implementation of these Category 1 projects will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and

uninsured populations. Therefore, the successful implementation of the associated Category 1 projects will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in these residency-related metrics will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 projects to address the community's need for more primary care and specialty care providers. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.6	*IT-14.6*	*Nursing Residency Training Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.6*		
Starting Point/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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $99,831	**Process Milestone 2** [P-2]: Establish baseline rates. Baseline is 15 surveys completed by the Graduate Nurses who are entering the Nurse Residency Program. Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $115,717	**Outcome Improvement Target 1** [IT-14.6]: Percent of trainees who have spent at least 5 years living in an HPSA or MUA. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 1 Estimated Incentive Payment*:* $185,687	**Outcome Improvement Target 4** [IT-14.6]: Percent of trainees who have spent at least 5 years living in an HPSA or MUA. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 4 Estimated Incentive Payment*:* $444,033
Year 2 Estimated Outcome Amount: $99,831	Year 3 Estimated Outcome Amount: $115,717	Year 4 Estimated Outcome Amount: $185,687	Year 5 Estimated Outcome Amount: $444,033
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $845,268			

94981

Title of Outcome Measure (Improvement Target): IT-12.6: Other Outcome Improvement Target — Hemoglobin A1c Measurement: decrease to 8% or below for patients discharged to the NHCs with Diabetes within 1 year

Unique RHP outcome identification number(s): 138951211.3.7

Outcome Measure Description:
IT-12.5: Other Outcome Improvement Target—Hemoglobin A1c Measurement: decrease to 8% or below for patients discharged to the NHCs with Diabetes within 1 year

- Rate 1: Hemoglobin A1c Measurement (138951211.1.7)

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 for rate 1

Outcome Improvement Targets for each year:
IT-12.6 Other Outcome Improvement Measure: Hemoglobin A1c Measurement: reduce Hemoglobin A1c Measurements in patient discharged to the NHCs to below 8% within 1 year.

- DY4 goal: have 40% of the patients have a HbA1c less than 8% after 1 year in the program
- DY5 goal: have 50% of the patients have a HbA1c less than 8% after 1 year in the program

Rationale:
This outcome is a complement to the Category 1 project that focuses on improving quality improvement in the NHCs. Many of UMC's projects focus on providing better follow up care to achieve more complete results. In addition to reducing ED admissions, the quality improvement initiative will help manage patients with chronic disease, which will tie to their Hemoglobin A1c Measurement. Monitoring a diabetes patient'sA1c level is critical for managing the disease itself.

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in Hemoglobin A1c Measurements will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 project to improve quality of care and thereby improve patient outcomes for the target population and any challenges or impediments to program implementation.

138951211.3.7	*IT-12.6*	*Other Outcome Improvement Target: Hemoglobin A1c Measurement*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.7*		
Starting Point/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: Documentation of project planning. Goal: Hold 2 meetings per month Process Milestone 1 Estimated Incentive Payment: $159,730	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EMR Goal: Program started and baseline rates established Process Milestone 2 Estimated Incentive Payment: $185,148	**Outcome Improvement Target 1** [IT-12.6]: Hemoglobin A1c Measurement Improvement Target: reduce the hemoglobin A1c to less than 8% in our patients Data Source: EMR • DY4 goal: have 40% of the patients have a HbA1c less than 8% after 1 year in the program Outcome Improvement Target 1 Estimated Incentive Payment*:* $297,098	**Outcome Improvement Target 2** [IT-12.6]: Hemoglobin A1c Measurement Improvement Target: reduce the hemoglobin A1c to less than 8% in our patients Data Source: EMR • DY5 goal: have 50% of the patients have a HbA1c less than 8% after 1 year in the program Outcome Improvement Target 2 Estimated Incentive Payment*:* $710,452
Year 2 Estimated Outcome Amount: $159,730	Year 3 Estimated Outcome Amount: $185,148	Year 4 Estimated Outcome Amount: $297,098	Year 5 Estimated Outcome Amount: $710,452
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,352,428			

95030

Title of Outcome Measure (Improvement Target): IT-11.5: Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT-3.1: All-cause 30-day readmission rate for discharges of inpatients who received inpatient psychiatric services

Unique RHP outcome identification number(s): 138951211.3.8

Performing Provider Name and TPI: University Medical Center of El Paso / TPI: 138951211

Outcome Measure Description:

IT- 11.5- Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT 3.1: All cause 30 day readmission rate of inpatients who received inpatient psychiatric services

- Rate 1: Discharges of inpatients who received inpatient psychiatric services (138951211.1.8)

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 for rates 1 through 4

Outcome Improvement Targets for each year:

- DY4:
  - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service—10% improvement over DY3
- DY5:
  - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service —15% improvement over DY4

Rationale:

This Category 3 outcome is related to four Category 1 or 2 projects: "Provide Psychiatric Care, Counseling, and Nursing at UMC Through Psychiatric Liaison Service"; "The Salvation Army, Redshield Health—A Holistic Wellness Program for the Homeless"; "Rescue Mission/VNA Shelter Program for the Homeless"; and "Discharge Navigation/Facilitation for High-Risk Patients." UMC believes that the successful implementation of these projects will result in an improvement in this Category 3 outcome.

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization for diabetes patients, for example, can be reduced when a diabetes patient has access to follow-up care and disease management services. A measurable reduction in UMC's all-cause 30-day readmission rate will indicate that UMC has made progress towards the goals of its associated Category 1 and Category 2

projects by successfully targeting patients in these marginalized settings. In order to record this reduction, UMC must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which a reduction in the all-cause 30-day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 and Category 2 projects to improve quality of care and thereby improve patient outcomes for patients who have received the specified inpatient services at UMC and/or been discharged to the specified programs supported by UMC. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.8	*IT-11.5*	Other Category 3 Outcome IT 3.1: All cause 30 day readmission rate of inpatients who received inpatient psychiatric services	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.8*		
Starting Point/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: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $279,528	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $324,009	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $519,921	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 15% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,243,290
Year 2 Estimated Outcome Amount: $279,528	Year 3 Estimated Outcome Amount: $324,009	Year 4 Estimated Outcome Amount: $519,921	Year 5 Estimated Outcome Amount: $1,243,290
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,366,748			

94730

Title of Outcome Measure (Improvement Target): IT-11.5: Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT-3.1: All-cause 30-day readmission rate

Unique RHP outcome identification number(s): 138951211.3.9

Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Outcome Measure Description:

IT- 11.5- Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measureIT 3.1 All cause 30 day readmission rate

- Rate 1: Discharges to the Salvation Army (138951211.2.1)

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 for rates 1 through 4

Outcome Improvement Targets for each year:

- DY4:
    - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service—10% improvement over DY3
- DY5:
    - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service —15% improvement over DY4

Rationale:

This Category 3 outcome is related to four Category 1 or 2 projects: "Provide Psychiatric Care, Counseling, and Nursing at UMC Through Psychiatric Liaison Service"; "The Salvation Army, Redshield Health—A Holistic Wellness Program for the Homeless"; "Rescue Mission/VNA

Shelter Program for the Homeless"; and "Discharge Navigation/Facilitation for High-Risk Patients." UMC believes that the successful implementation of these projects will result in an improvement in this Category 3 outcome.

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization for diabetes patients, for example, can be reduced when a diabetes patient has access to follow-up care and disease management services. A measurable reduction in UMC's all-cause 30-day readmission rate will indicate that UMC has made progress towards the goals of its associated Category 1 and Category 2 projects by successfully targeting patients in these marginalized settings. In order to record this reduction, UMC must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which a reduction in the all-cause 30-day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 and Category 2 projects to improve quality of care and thereby improve patient outcomes for patients who have received the specified inpatient services at UMC and/or been discharged to the specified programs supported by UMC. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.9	*IT-11.5*	*Select Any Other Category 3 Outcome*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.1*		
Starting Point/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: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $259,561	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $300,865	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $482,784	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 15% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,154,484
Year 2 Estimated Outcome Amount: $259,561	Year 3 Estimated Outcome Amount: $300,865	Year 4 Estimated Outcome Amount: $482,784	Year 5 Estimated Outcome Amount: $1,154,484
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,197,695			

Title of Outcome Measure (Improvement Target): IT-11.5: Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT-3.1: All-cause 30-day readmission rate

Unique RHP outcome identification number(s): 138951211.3.10

Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Outcome Measure Description:

IT- 11.5- Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT 3.1: All cause 30 day readmission rate for discharges to the Rescue Mission

- Rate 1: Discharges to the Rescue Mission (138951211.2.2)

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 for rates 1 through 4

Outcome Improvement Targets for each year:

- DY4:
    - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service—10% improvement over DY3
- DY5:
    - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service —15% improvement over DY4

Rationale:

This Category 3 outcome is related to four Category 1 or 2 projects: "Provide Psychiatric Care, Counseling, and Nursing at UMC Through Psychiatric Liaison Service"; "The Salvation Army,

Redshield Health—A Holistic Wellness Program for the Homeless"; "Rescue Mission/VNA Shelter Program for the Homeless"; and "Discharge Navigation/Facilitation for High-Risk Patients." UMC believes that the successful implementation of these projects will result in an improvement in this Category 3 outcome.

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization for diabetes patients, for example, can be reduced when a diabetes patient has access to follow-up care and disease management services. A measurable reduction in UMC's all-cause 30-day readmission rate will indicate that UMC has made progress towards the goals of its associated Category 1 and Category 2 projects by successfully targeting patients in these marginalized settings. In order to record this reduction, UMC must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which a reduction in the all-cause 30-day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 and Category 2 projects to improve quality of care and thereby improve patient outcomes for patients who have received the specified inpatient services at UMC and/or been discharged to the specified programs supported by UMC. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.10	*IT-11.5*	Other Category 3 Outcome IT 3.1: All cause 30 day readmission rate for discharges to the Rescue Mission	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.2*		
Starting Point/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: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $159,730	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $185,148	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $297,098	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 15% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $710,452
Year 2 Estimated Outcome Amount: $159,730	Year 3 Estimated Outcome Amount: $185,148	Year 4 Estimated Outcome Amount: $297,098	Year 5 Estimated Outcome Amount: $710,452
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,352,428			

Title of Outcome Measure (Improvement Target): IT-11.5: Select any other Category 3 outcome IT-3.1: IT-3.1 30 Day Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program).

Unique RHP outcome identification number(s): 138951211.3.11

Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Outcome Measure Description:

IT- 11.5- Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure—IT 3.1: All cause 30 day readmission rate

- Rate 3: Discharges through Discharge Facilitation/Navigation for High-Risk Patients (138951211.2.3)

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 for rates 1 through 4

Outcome Improvement Targets for each year:

- DY4:
  - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service—10% improvement over DY3
- DY5:
  - IT-11.5; (IT-3.1): All-cause 30-day readmission rate for patients enrolled in each program/service —15% improvement over DY4

Rationale:

This Category 3 outcome is related to four Category 1 or 2 projects: "Provide Psychiatric Care, Counseling, and Nursing at UMC Through Psychiatric Liaison Service"; "The Salvation Army, Redshield Health—A Holistic Wellness Program for the Homeless"; "Rescue Mission/VNA

Shelter Program for the Homeless"; and "Discharge Navigation/Facilitation for High-Risk Patients." UMC believes that the successful implementation of these projects will result in an improvement in this Category 3 outcome.

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization for diabetes patients, for example, can be reduced when a diabetes patient has access to follow-up care and disease management services. A measurable reduction in UMC's all-cause 30-day readmission rate will indicate that UMC has made progress towards the goals of its associated Category 1 and Category 2 projects by successfully targeting patients in these marginalized settings. In order to record this reduction, UMC must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which a reduction in the all-cause 30-day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 and Category 2 projects to improve quality of care and thereby improve patient outcomes for patients who have received the specified inpatient services at UMC and/or been discharged to the specified programs supported by UMC. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.11	*IT-11.5*	*Other Outcomes Target (30 Readmission Rate for Patients enrolled in care transitions protocol under the Discharge Navigation Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.3*		
Starting Point/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: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $359,393	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $416,583	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $668,470	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 15% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,598,516
Year 2 Estimated Outcome Amount: $359,393	Year 3 Estimated Outcome Amount: $416,583	Year 4 Estimated Outcome Amount: $668,470	Year 5 Estimated Outcome Amount: $1,598,516
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,042,962			

Title of Outcome Measure (Improvement Target): IT-11.5, IT-3.12: Other Readmission Rate

Unique RHP outcome identification number(s): 138951211.3.12

Performing Provider Name/TPI: The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC) / TPI: 138951211

Outcome Measure Description:
IT-3.12: Other Readmission Rate

- Rate 1: NHC Medical Home Patients (138951211.2.4) – 30 day diabetes readmissions for NHC patient in this program

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 for rate 1

Outcome Improvement Targets for each year:

- DY4:
- IT-3.12: Other readmission rate 30 day diabetes readmissions for NHC patient in this program
  - —Rates 1: TBD improvement over DY3
- DY5:
- IT-3.12: Other readmission rate 30 day diabetes readmissions for NHC patient in this program
  - —Rates 1: TBD improvement over DY4

Rationale:

UMC plans to implement several Category 2 projects aimed at reducing readmission rates for specific patient populations with an identified need ("NHC Medical Home Expansion"; "Expand Chronic Care Management Model Programs and Services at the UMC Neighborhood Health Centers"; "Conduct Medication Management—Establish a Coumadin Clinic at UMC Neighborhood Health Centers"; and "Complete Hospice Care for Uncompensated Patients"). These projects will focus on post-surgical patients, patients receiving post-discharge care in the NHC medical homes, diabetes patients receiving post-discharge care under the chronic care management model, and patients receiving post-discharge care under Coumadin clinic programs. These programs are designed to give each patient the right care in the right setting. UMC feels that appropriate follow-up and better monitoring of patients post-discharge will lower readmission rates for these focused populations.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in readmission rates for patients discharged under these new programs established with the projects listed will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 2 project to inform patients of appropriate pre-surgery and post-surgery self-care regimens and of support resources available to them in the community, leading to better outcomes and fewer readmissions. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.12	*IT-11.5*	*Other Readmission Rate: 3.12 30 day diabetes*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.4*		
Starting Point/Baseline:	*TBD DY3 – New Programs*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $339,426	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $393,439	**Outcome Improvement Target 1** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $631,333	**Outcome Improvement Target 2** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 15% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,509,710
Year 2 Estimated Outcome Amount: $339,426	Year 3 Estimated Outcome Amount: $393,439	Year 4 Estimated Outcome Amount: $631,333	Year 5 Estimated Outcome Amount: $1,509,710
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,873,909			

Title of Outcome Measure (Improvement Target): **IT-11.5, IT-3.12**: Other Readmission Rate diabetes 30 day readmission rates for patients receiving diabetes care under the chronic care model in the NHCs.

Unique RHP outcome identification number(s): 138951211.3.13

Performing Provider Name and TPI: University medical Center of El Paso / 138951211

Outcome Measure Description:
IT-3.12: Other Readmission Rate

- Rate 1: NHC Chronic Care (138951211.2.5) – diabetes 30 day readmission rates for patients receiving diabetes care under the chronic care model in the NHCs.

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 for rate 1

Outcome Improvement Targets for each year:

- DY4: IT-3.12: Other readmission rate diabetes 30 day readmission rates for patients receiving diabetes care under the chronic care model in the NHCs.
    - —Rates 1: TBD improvement over DY3
- DY5:
- IT-3.12: Other readmission rate 30 day readmission rates for patients receiving diabetes care under the chronic care model in the NHCs.
    - —Rates 1: TBD improvement over DY4

Rationale:

UMC plans to implement several Category 2 projects aimed at reducing readmission rates for specific patient populations with an identified need ("NHC Medical Home Expansion"; "Expand Chronic Care Management Model Programs and Services at the UMC Neighborhood Health Centers"; "Conduct Medication Management—Establish a Coumadin Clinic at UMC Neighborhood Health Centers"; and "Complete Hospice Care for Uncompensated Patients"). These projects will focus on post-surgical patients, patients receiving post-discharge care in the NHC medical homes, diabetes patients receiving post-discharge care under the chronic care management model, and patients receiving post-discharge care under Coumadin clinic programs. These programs are designed to give each patient the right care in the right setting. UMC feels

that appropriate follow-up and better monitoring of patients post-discharge will lower readmission rates for these focused populations.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in readmission rates for patients discharged under these new programs established with the projects listed will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 2 project to inform patients of appropriate pre-surgery and post-surgery self-care regimens and of support resources available to them in the community, leading to better outcomes and fewer readmissions. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.13	*IT-11.5*	*Other Readmission Rate* 30 day readmission rates for patients receiving diabetes care under the chronic care model in the NHCs**.**	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.5*		
Starting Point/Baseline:	*TBD DY3 – New Programs*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $219,629	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Goal: Establish Baseline rate Process Milestone 2 Estimated Incentive Payment: $254,578	**Outcome Improvement Target 1** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $408,510	**Outcome Improvement Target 2** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 15% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $976,871
Year 2 Estimated Outcome Amount: $219,629	Year 3 Estimated Outcome Amount: $254,578	Year 4 Estimated Outcome Amount: $408,510	Year 5 Estimated Outcome Amount: $976,871
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,859,588			

Title of Outcome Measure (Improvement Target): **IT-11.5, IT-3.12**: Other Readmission Rate

Unique RHP outcome identification number(s): 138951211.3.14

Provider Name and TPI: University Medical Center of El Paso: 138951211

Outcome Measure Description:
IT-3.12: Other Readmission Rate

- Rate1: NHC Coumadin Clinic (138951211.2.6) – coronary artery disease and stroke 30-day readmission rates for the population receiving care from the Coumadin clinics at the NHCs.

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 for rate 1 – rate 4

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.12: Other readmission rate —Rates 1-4: 5% improvement over DY3
- DY5:
  - IT-3.12: Other readmission rate —Rates 1-4: 3% improvement over DY4

Rationale:

UMC plans to implement several Category 2 projects aimed at reducing readmission rates for specific patient populations with an identified need ("NHC Medical Home Expansion"; "Expand Chronic Care Management Model Programs and Services at the UMC Neighborhood Health Centers"; "Conduct Medication Management—Establish a Coumadin Clinic at UMC Neighborhood Health Centers"; and "Complete Hospice Care for Uncompensated Patients"). These projects will focus on post-surgical patients, patients receiving post-discharge care in the NHC medical homes, diabetes patients receiving post-discharge care under the chronic care management model, and patients receiving post-discharge care under Coumadin clinic programs. These programs are designed to give each patient the right care in the right setting. UMC feels that appropriate follow-up and better monitoring of patients post-discharge will lower readmission rates for these focused populations.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in readmission rates for patients discharged under these new programs established with the projects listed will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the

improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 2 project to inform patients of appropriate pre-surgery and post-surgery self-care regimens and of support resources available to them in the community, leading to better outcomes and fewer readmissions. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.14	*IT-11.5 (IT3.12)*	*Other Readmission Rate*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.6*		
Starting Point/Baseline:	*TBD DY3 – New Programs*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $299,494	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Goal: Baseline rate established Process Milestone 2 Estimated Incentive Payment: $347,152	**Outcome Improvement Target 1** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $557,059	**Outcome Improvement Target 2** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 3% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,332,097
Year 2 Estimated Outcome Amount: $299,494	Year 3 Estimated Outcome Amount: $347,152	Year 4 Estimated Outcome Amount: $557,059	Year 5 Estimated Outcome Amount: $1,332,097
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,535,802			

Title of Outcome Measure (Improvement Target): IT-13.4: Proportion admitted to the hospital in the last 30 days of life (NQF 0213)

Unique RHP outcome identification number(s): 138951211.3.15

Performing Provider Name/TPI: University Medical Center of El Paso (UMC) / TPI: 138951211

Outcome Measure Description:
IT-13.4: Proportion admitted to the hospital in the last 30 days of life

- Rate 1: Percentage of patients who died from MCC admitted to the hospital in the last 30 days of life (138951211.2.7)

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 for rate 1

Outcome Improvement Targets for each year:

- DY4:
    - IT-13.4: Proportion admitted to the Hospital in the last 30 days of life (NQF 0213)—TBD improvement over DY3
- DY5:
    - IT-13.4: Proportion admitted to the Hospital in the last 30 days of life (NQF 0213)—TBD improvement over DY4

Rationale:
Through the implementation of the hospice and palliative care plan described in the associated Category 2 project, UMC believes that patients will experience better outcomes, meaning that these patients will not require intensive care and will not need to be admitted to the ICU. Accordingly, UMC believes that the successful implementation of this associated Category 2 project will be accompanied by a reduction in the proportion of patients served by the project who are admitted to UMC's ICU in the last 30 days of life

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in the availability and effectiveness of hospice care will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 2 project to improve quality of care and thereby

improve patient outcomes for the target population. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.15	*IT-13.4*	*Proportion Admitted to the hospital in the Last 30 Days of Life*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.7*		
Starting Point/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: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $259,561	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $300,865	**Outcome Improvement Target 1** [IT-13.4]: Proportion admitted to the hospital in the last 30 days of life. Numerator: Patients who died from MCC and were admitted to the hospital in the last 30 days of life. Denominator: Patients who died from MCC in hospital Improvement Target: TBD improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $482,784	**Outcome Improvement Target 2** [IT-13.4]: Proportion admitted to the hospital in the last 30 days of life. Numerator: Patients who died from MCC and were admitted to the hospital in the last 30 days of life. Denominator: Patients who died from MCC in hospital Improvement Target: TBD improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,154,484
Year 2 Estimated Outcome Amount: $259,561	Year 3 Estimated Outcome Amount: $300,865	Year 4 Estimated Outcome Amount: $482,784	Year 5 Estimated Outcome Amount: $1,154,484
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,197,695			

Title of Outcome Measure (Improvement Target): IT-11.5, IT-3.12: Other Readmission Rate

Unique RHP outcome identification number(s): 138951211.3.16

Outcome Measure Description:
IT-3.12: Other Readmission Rate

- Rate 1: Post-surgical patients (138951211.2.8) – all cause Readmissions for patients in this program

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 for rate 1 – rate 4

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.12: Other readmission rate —Rates 1-4: TBD improvement over DY3

- DY5:
  - IT-3.12: Other readmission rate —Rates 1-4: TBD improvement over DY4

Rationale:

UMC plans to implement several Category 2 projects aimed at reducing readmission rates for specific patient populations with an identified need ("NHC Medical Home Expansion"; "Expand Chronic Care Management Model Programs and Services at the UMC Neighborhood Health Centers"; "Conduct Medication Management—Establish a Coumadin Clinic at UMC Neighborhood Health Centers"; and "Complete Hospice Care for Uncompensated Patients"). These projects will focus on post-surgical patients, patients receiving post-discharge care in the NHC medical homes, diabetes patients receiving post-discharge care under the chronic care management model, and patients receiving post-discharge care under Coumadin clinic programs. These programs are designed to give each patient the right care in the right setting. UMC feels that appropriate follow-up and better monitoring of patients post-discharge will lower readmission rates for these focused populations.

We did not use the outcome measure for surgical site infection rates since our current hospital score for this is relatively good based on national standards, thus not much room for improvement. We want to target the entire population of surgical patients, provide education early on, and be a constant resource for advice when the patient may have changes in their health status or other questions, as this will be a 24/7 advice line. This is a large number of patients that we may prevent from returning to the ED and get them healthier while preventing adverse events.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in readmission rates for patients discharged under these new programs established with the projects listed will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 2 project to inform patients of appropriate pre-surgery and post-surgery self-care regimens and of support resources available to them in the community, leading to better outcomes and fewer readmissions. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.16	*IT-11.5*	*Other Readmission Rate*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.8*		
Starting Point/Baseline:	*TBD DY3 – New Programs*		
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 project planning. Process Milestone 1 Estimated Incentive Payment: $239,595	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 2 Estimated Incentive Payment: $277,722	**Outcome Improvement Target 1** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 10% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $445,647	**Outcome Improvement Target 2** [IT-3.12]: Other readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions for patients discharged from the hospital in each new program established under these projects Improvement Target: 15% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,065,677
Year 2 Estimated Outcome Amount: $239,595	Year 3 Estimated Outcome Amount: $277,722	Year 4 Estimated Outcome Amount: $445,647	Year 5 Estimated Outcome Amount: $1,065,677
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,028,641			

Title of Outcome Measure (Improvement Target): **IT-9.4**: Other Outcome Improvement Target. Overall wait times for Emergency Department (ED) Patients; Reduction in left-without-being-seen rates for ED Patients.

Unique RHP outcome identification number(s): 138951211.3.17 Pass 2

Performing Provider Name and TPI: University Medical Center of El Paso / TPI: 138951211

Outcome Measure Description:
IT-9.4: Other Outcome Improvement Target

- Overall wait times for Emergency Department (ED) Patients; Reduction in left-without-being-seen rates for ED Patients. (138951211.2.9)

Process Milestones:

- DY2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- DY2: P-2 – Establish baseline rates - 1. For the second quarter 2012, period July to September, average wait time was 2:21 hours. - 2. For the second quarter 2012, period July to September, average Left-Without-Being-Seen rate was 9.07%

- DY3: P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome Improvement Targets for each year:

- DY4: IT-9.4: Other Outcome Improvement Target —6% improvement over DY2. 1. Goal for average wait time = 2:12 hours. - 2. Goal for average Left-Without-Being-Seen rate = 7.5%

- DY5: IT-9.4: Other Outcome Improvement Target —12% improvement over DY2. 1. Goal for average wait time = 2:04 hours. - 2. Goal for average Left-Without-Being-Seen rate = 6.5%

Rationale:
University Medical Center of El Paso believes that the associated Category 2 project (i.e., applying LEAN principles to hospital throughput to improve emergency department throughput and reduce admission process times) will result in a reduction of wait times and Left-Without-Being-Seen (LWBS) rates in the Emergency Department. The Agency for Healthcare Research and Quality publication dated October 2011 states long ED wait times and ED crowding contribute to poor quality care. (AHRQ publication no. 11(12)-0094) Patients who leave without being seen are a glaring measure of impaired health care access. (Annals of Emergency Medicine July 2011).

The ED at UMC demonstrates poor throughput resulting in high wait times and high LWBS rates. The current admission process through the ED is cumbersome and lengthy and creates a backlog of patients in the ED waiting room. In addition, clinic patients are referred to the ED for assessment and admission to the hospital causing further back up of patients awaiting inpatient beds. Improving hospital admission processes and throughput at UMC will have a direct impact on ED throughput and improving on giving the right care in the right setting.
By implementing LEAN manufacturing principles to a healthcare delivery system, the hospital will improve hospital throughput and increase bed availability resulting in shorter ED wait times and a decrease in LWBS rates in the ED.

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in wait times and LWBS rates in the ED would benefit our patients, how it will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the project's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 2 project to lead to better outcomes. The valuation of this outcome measure also takes into account the challenges that UMC will face as the county hospital, a safety net hospital, in realizing and measuring this improvement. This project also has a potential savings to the overall healthcare delivery system because there are significant costs and health complications that can be avoided when a patient population receives timely treatment for their conditions, rather than leaving the ED without being seen. UMC took into consideration the patient and community benefit that is achieved by providing timely care, which is critical in preventing unnecessary decline in the patient's condition.

138951211.3.17Pass 2	*IT-9.4*	Overall wait times for Emergency Department (ED) Patients; Reduction in left-without-being-seen rates for ED Patients.	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.2.9 Pass 2*		
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: Documentation of project planning. **Process Milestone 2** [P-2]: Establish baseline rates. 1. For the second quarter 2012, period July to September, average wait time for ED was 2:21 hours. 2. For the second quarter 2012, period July to September, average Left-Without-Being-Seen rate for ED was 9.07%. Data Source: Department of Emergency Medicine Daily/Monthly Reports Process Milestone 1 Estimated Incentive Payment: $93,057	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. 1. LEAN methodology utilizes PDSA cycles to assess data, identify areas for improvement and rapid intervention. Data Source: Department of Emergency Medicine Daily/Monthly Reports and A-3 (PDSA) reports. Process Milestone 2 Estimated Incentive Payment: $107,869	**Outcome Improvement Target 1** [IT-9.4]: Other Outcome Improvement 1. Goal for average wait time = 2:12 hours. – 6% improvement over DY2. 2. Goal for average Left-Without-Being-Seen rate of 7.5%. Improvement Target: 6% improvement over DY2. Data Source: Department of Emergency Medicine Daily/Monthly Reports. Outcome Improvement Target 1 Estimated Incentive Payment: $173,078	**Outcome Improvement Target 2** [IT-9.4]: Other Outcome Improvement 1. Goal for average wait time = 2:04 hours. – 12% improvement over DY2. 2. Goal for average Left-Without-Being-Seen rate of 6.5%. Improvement Target: 12% improvement over DY2. Data Source: Department of Emergency Medicine Daily/Monthly Reports. Outcome Improvement Target 2 Estimated Incentive Payment: $413,887
Year 2 Estimated Outcome Amount: $93,056	Year 3 Estimated Outcome Amount: $107,869	Year 4 Estimated Outcome Amount: $173,078	Year 5 Estimated Outcome Amount: $413,888
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $787,891			

Title of Outcome Measure (Improvement Target): IT-14.7: Primary Care Residency Training Program

Unique RHP outcome identification number(s): 138951211.3.18

Outcome Measure Description:
IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

- Rate 1: Percent of residency program trainees who report that they plan to practice in HPSAs or MUAs (138951211.1.1)

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 for rates 1 and 2. Survey 100 Residents

Outcome Improvement Targets for each year:

- DY4:
  - IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey—10% improvement over DY3 baseline
- DY5:
  - IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey—20% improvement over DY3 baseline

Rationale:
UMC's Category 1 residency program and nurse residency program projects ("Expanded Residency Program" and "Establish Nurse Residency and Simulation Lab") are intended, in part, to leverage new or existing residency training programs in order to recruit more physicians and mid-level providers to underserved areas of the state, including El Paso. UMC believes that the successful implementation of these Category 1 projects will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 projects will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in these residency-related metrics will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while

containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 projects to address the community's need for more primary care and specialty care providers. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.18	*IT-14.7*	*Primary Care Residency Training Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.1*		
Starting Point/Baseline:	*Survey 100 Residents*		
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 project planning Process Milestone 1 Estimated Incentive Payment: $126,453	**Process Milestone 2** [P-2]: Establish baseline rates. Survey 100 Residents Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $146,575	**Outcome Improvement Target 2** [IT-14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 2 Estimated Incentive Payment*:* $235,203	**Outcome Improvement Target 5** [IT-14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 5 Estimated Incentive Payment*:* $562,441
Year 2 Estimated Outcome Amount: $126,453	Year 3 Estimated Outcome Amount: $146,575	Year 4 Estimated Outcome Amount: $235,203	Year 5 Estimated Outcome Amount: $562,441
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,070,672			

Title of Outcome Measure (Improvement Target): IT-14.8: Primary Care Residency Training Program

Unique RHP outcome identification number(s): 138951211.3.19

Outcome Measure Description:
IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

- Rate 1: Percent of residency program trainees who report that they plan to serve Medicaid populations (138951211.1.1)

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 for rates 1 and 2. Survey 100 Residents

Outcome Improvement Targets for each year:

- DY4:
  - IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey—10% improvement over DY3 baseline
- DY5:
  - IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey—20% improvement over DY3 baseline

Rationale:
UMC's Category 1 residency program and nurse residency program projects ("Expanded Residency Program" and "Establish Nurse Residency and Simulation Lab") are intended, in part, to leverage new or existing residency training programs in order to recruit more physicians and mid-level providers to underserved areas of the state, including El Paso. UMC believes that the successful implementation of these Category 1 projects will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 projects will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:
In determining the value of this outcome measure, UMC considered the extent to which an improvement in these residency-related metrics will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while

containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 projects to address the community's need for more primary care and specialty care providers. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.19	*IT-14.8*	*Primary Care Residency Training Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.1*		
Starting Point/Baseline:	*Survey 100 Residents*		
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 project planning Process Milestone 1 Estimated Incentive Payment: $126,453	**Process Milestone 2** [P-2]: Establish baseline rates. Survey 100 Residents Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $146,575	**Outcome Improvement Target 3** [IT-14.8]: Percent of trainees who report that they plan to serve Medicaid populations. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 3 Estimated Incentive Payment: $235,202	**Outcome Improvement Target 6** [IT-14.8]: Percent of trainees who report that they plan to serve Medicaid populations. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 6 Estimated Incentive Payment: $562,441
Year 2 Estimated Outcome Amount: $126,453	Year 3 Estimated Outcome Amount: $146,575	Year 4 Estimated Outcome Amount: $235,202	Year 5 Estimated Outcome Amount: $562,441
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,070,671			

Title of Outcome Measure (Improvement Target): IT-14.7: Nursing Residency Training Program

Unique RHP outcome identification number(s): 138951211.3.20

Outcome Measure Description:
IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

- Rate 1: Percent of nursing residency program trainees who report that they plan to practice in HPSAs or MUAs (138951211.1.6)

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 for rates 1 and 2. Baseline for DY3 is 15 Nurse Graduates to enter Nurse Residency Program. At the conclusion of the waiver, a total of 53 Nurse Graduates are to complete the Nurse Residency Program.

Outcome Improvement Targets for each year:

- DY4:
    - IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey—10% improvement over DY3 baseline
- DY5:
    - IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey—20% improvement over DY3 baseline

Rationale:
UMC's Category 1 residency program and nurse residency program projects ("Expanded Residency Program" and "Establish Nurse Residency and Simulation Lab") are intended, in part, to leverage new or existing residency training programs in order to recruit more physicians and mid-level providers to underserved areas of the state, including El Paso. UMC believes that the

successful implementation of these Category 1 projects will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 projects will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in these residency-related metrics will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 projects to address the community's need for more primary care and specialty care providers. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.20	*IT-14.7*	*Nursing Residency Training Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.6*		
Starting Point/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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $99,831	**Process Milestone 2** [P-2]: Establish baseline rates. Baseline is 15 surveys completed by the Graduate Nurses who are entering the Nurse Residency Program. Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $115,718	**Outcome Improvement Target 2** [IT-14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 2 Estimated Incentive Payment*:* $185,686	**Outcome Improvement Target 5** [IT-14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 5 Estimated Incentive Payment*:* $444,032
Year 2 Estimated Outcome Amount: $99,831	Year 3 Estimated Outcome Amount: $115,718	Year 4 Estimated Outcome Amount: $185,686	Year 5 Estimated Outcome Amount: $444,032
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $845,267			

Title of Outcome Measure (Improvement Target): IT-14.8: Nursing Residency Training Program

Unique RHP outcome identification number(s): 138951211.3.21

Outcome Measure Description:
IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

- Rate 1: Percent of nursing residency program trainees who report that they plan to serve Medicaid populations (138951211.1.6)

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 for rates 1 and 2. Baseline for DY3 is 15 Nurse Graduates to enter Nurse Residency Program. At the conclusion of the waiver, a total of 53 Nurse Graduates are to complete the Nurse Residency Program.

Outcome Improvement Targets for each year:

- DY4:
  - IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey—10% improvement over DY3 baseline
- DY5:
  - IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey—20% improvement over DY3 baseline

Rationale:
UMC's Category 1 residency program and nurse residency program projects ("Expanded Residency Program" and "Establish Nurse Residency and Simulation Lab") are intended, in part, to leverage new or existing residency training programs in order to recruit more physicians and

mid-level providers to underserved areas of the state, including El Paso. UMC believes that the successful implementation of these Category 1 projects will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 projects will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:

In determining the value of this outcome measure, UMC considered the extent to which an improvement in these residency-related metrics will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing the associated Category 1 projects to address the community's need for more primary care and specialty care providers. The valuation of this outcome measure also takes into account the challenges that UMC will face in realizing and measuring this improvement.

138951211.3.21	*IT-14.8*	*Nursing Residency Training Program*	
University Medical Center of El Paso			*138951211*
Related Category 1 or 2 Projects:	*138951211.1.6*		
Starting Point/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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $99,832	**Process Milestone 2** [P-2]: Establish baseline rates. Baseline is 15 surveys completed by the Graduate Nurses who are entering the Nurse Residency Program. Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $115,717	**Outcome Improvement Target 3** [IT-14.6]: Percent of trainees who report that they plan to serve Medicaid populations. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 3 Estimated Incentive Payment*:* $185,686	**Outcome Improvement Target 6** [IT-14.6]: Percent of trainees who report that they plan to serve Medicaid populations. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 6 Estimated Incentive Payment*:* $444,032
Year 2 Estimated Outcome Amount: $99,832	Year 3 Estimated Outcome Amount: $115,717	Year 4 Estimated Outcome Amount: $185,686	Year 5 Estimated Outcome Amount: $444,032
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $845,267			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 094109802.3.1
Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate. In DY 5, LPDS intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—5% improvement over DY3

Rationale:

This Category 3 outcome is tied to LPDS's Primary Care Physician Recruitment project (094109802.1.1), but LPDS expects that the outcome will be positively impacted by two additional related Category 1 or 2 projects: LPDS's Outpatient Women's Services Expansion project (094109802.1.2), and LPDS's Evaluate Hospitalist Model project (094109802.2.3).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by LPDS's Primary Care Physician Recruitment project (094109802.1.1) and Outpatient Women's Services Expansion project (094109802.1.2), and LPDS expects to see an improvement in patient satisfaction as a result—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information.

Another challenge stemming from El Paso's lack of primary care capacity is the overburdening of existing primary care physicians, meaning that these physicians often do not see inpatients in a timely fashion. As a result, inpatient care is less coordinated and effective than it could be. This challenge will be addressed by LPDS's Evaluate Hospitalist Model project (094109802.2.3), and LPDS expects to see an improvement in patient satisfaction as a result—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information, and patients' rating of how well their doctors communicate.

Outcome Measure Valuation:

$1,911,450. In determining the value of this outcome measure, LPDS considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether LPDS's related Category 1 and 2 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges that LPDS will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

094109802.3.1	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.1.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $225,754	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $261,678	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $419,903	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $1,004,115
Year 2 Estimated Outcome Amount: $225,754	Year 3 Estimated Outcome Amount: $261,678	Year 4 Estimated Outcome Amount: $419,903	Year 5 Estimated Outcome Amount: $1,004,115
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,911,450			

Title of Outcome Measure (Improvement Target): IT-8.2 – Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) Our goal is to improve the percentage of low-weight births by 5% in DY4, and 10% in DY5.

Unique RHP outcome identification number(s): 094109802.3.2

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to decrease the percentage of low-weight births by 5% over the baseline recorded in DY 3. In DY 5, LPDS intends to decrease the percentage of low-weight births by 10% over the baseline recorded in DY3 .

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-8.2 – Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) – decrease the percentage of low-weight births by 5% in DY4 over DY3.
- DY5:
  - IT-8.2 – Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) – decrease the percentage of low-weight births by 10% in DY5 over DY3.

Rationale:

The Outpatient Women's Services Expansion project will establish 4 additional Outpatient Women's Centers, which will offer resources to women that are pregnant, regardless of ability to pay. The Outpatient Women's Center will coordinate with the local primary care physician community to offer primary care appointments within 48 hours of their Women's Center visit. As a result of this intervention and partnership with primary care resources, women in the El Paso community will have access prenatal care much earlier in their pregnancy, which will result in better outcomes for the mother and baby. This project will reduce the percentage of low-weight births by offering outpatient women's services to those that cannot afford, or do not have access to a primary care physician. The goal of this project is to get women in the El Paso community the early interventions that can be so crucial in a healthy birth. This project will also increase community awareness of the healthcare services provided by the clinic and provide additional education to ensure the population is accessing the right care in the right setting.

This Category 3 outcome is tied to LPDS's Outpatient Women's Services Expansion project (094109802.1.2), but LPDS expects that the overall strategy to improve access to primary and

specialty care will be positively impacted by two additional related Category 1 or 2 projects: LPDS's Primary Care Physician Recruitment project (094109802.1.1), and LPDS's Evaluate Hospitalist Model project (094109802.2.3).

Outcome Measure Valuation:

$1,236,820. In determining the value of this outcome measure, LPDS considered the extent to which a reduction in the percentage of low birth weights will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the significant cost-savings to the overall healthcare system by achieving early intervention and higher rates of early and ongoing prenatal care. The valuation of this outcome measure also takes into account the challenges that LPDS will face in establishing and maintaining the operations of 4 additional clinics, which will see about 8,000 additional patients per year during the Waiver term and beyond. .

094109802.3.2	*IT 8.2*	***Percentage of Low-weight births (CHIPRA #1382)***	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.1.2*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $146,076	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $169,321	**Outcome Improvement Target 1** [IT 8.2]: Percentage of Low-weight births (CHIPRA #1382). Improvement Target: 5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $271,702	**Outcome Improvement Target 2** [IT 8.2]: Percent improvement over baseline of patient satisfaction scores. Improvement Target:10% improvement over DY3 . Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $649,721
Year 2 Estimated Outcome Amount: $146,076	Year 3 Estimated Outcome Amount: $169,321	Year 4 Estimated Outcome Amount: $271,702	Year 5 Estimated Outcome Amount: $649,721
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,236,820			

95786

Title of Outcome Measure (Improvement Target): IT-3.3: Diabetes 30-Day Readmission Rate

Unique RHP outcome identification number(s): 094109802.3.3

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its diabetes 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, LPDS intends to improve its diabetes 30-day readmission rate by at least 2.5% over the DY 4 measurement.

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-3.3: Diabetes 30-day readmission rate—2.5% improvement over DY3
- DY5:

  IT-3.3: Diabetes 30-day readmission rate— 5% improvement over DY3

Rationale:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization for diabetes patients can be reduced when a diabetes patient registry is successfully implemented to allow better management of patients' diabetes-related conditions. A measurable reduction in LPDS's diabetes 30-day readmission rate will indicate that LPDS has made progress towards these goals. In order to record this reduction, LPDS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:
$1,799,011. In determining the value of this outcome measure, LPDS considered the extent to which a reduction in the BH/SA admission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing a hospital-wide diabetes

registry to improve quality of care and thereby improve patient outcomes for diabetes patients. The valuation of this outcome measure also takes into account the challenges that LPDS will face in realizing this improvement in the hospital setting.

094109802.3.3	*IT-3.3*	*Diabetes 30-Day Readmission Rate*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.1.3*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $212,474	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $246,286	**Outcome Improvement Target 1** [IT-3.3]: Diabetes 30-day readmission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $395,202	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30-day readmission rate. Improvement Target: 5% improvement over DY3 Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $945,049
Year 2 Estimated Outcome Amount: $212,474	Year 3 Estimated Outcome Amount: $246,286	Year 4 Estimated Outcome Amount: $395,202	Year 5 Estimated Outcome Amount: $945,049
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,799,011			

94614

Title of Outcome Measure (Improvement Target): IT-2.4: Behavioral Health/Substance Abuse (BH/SA) Admission Rate

Unique RHP outcome identification number(s): 094109802.3.4

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its behavioral health/substance abuse (BH/SA) admission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, LPDS intends to improve its BH/SA admission rate by at least 5% over the DY3 measurement.

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-2.4: Behavioral Health/Substance Abuse (BH/SA) admission rate—2.5% improvement over DY3
- DY5:
  - IT-2.4: Behavioral Health/Substance Abuse (BH/SA) admission rate— 5% improvement over DY3

Rationale:

Behavioral health consumers frequently wait hours or even days in crowded EDs before receiving psychiatric evaluation and placement. Hospital reports show that patients with behavioral health concerns typically experience longer inpatient stays than other patients. Avoidable hospitalizations for these patients can be reduced by providing more timely consults from psychiatric specialists via tele-psychiatry services. A measurable reduction in LPDS's BH/SA admission rate will indicate that LPDS has made progress towards these goals. In order to record this reduction, LPDS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:
$1,124,382. In determining the value of this outcome measure, LPDS considered the extent to which a reduction in the BH/SA admission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including

supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of implementing tele-psychiatry to improve quality of care and thereby improve patient outcomes for BH/SA patients. The valuation of this outcome measure also takes into account the challenges that LPDS will face in realizing this technological infrastructure improvement in the hospital setting. The valuation of this outcome measure also takes into account the challenges that LPDS will face in realizing this improvement in the hospital setting.

094109802.3.4	*IT-2.4*	*Behavioral Health/Substance Abuse (BH/SA) Admission Rate*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.1.4*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $132,796	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $153,928	**Outcome Improvement Target 1** [IT-2.4]: Behavioral Health/Substance Abuse (BH/SA) admission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $247,001	**Outcome Improvement Target 2** [IT-2.4]: Behavioral Health/Substance Abuse (BH/SA) admission rate. Improvement Target: 5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $590,656
Year 2 Estimated Outcome Amount: $132,796	Year 3 Estimated Outcome Amount: $153,928	Year 4 Estimated Outcome Amount: $247,001	Year 5 Estimated Outcome Amount: $590,656
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,124,382			

95780

Title of Outcome Measure (Improvement Target): IT-3.1: All-Cause 30-Day Readmission Rate

Unique RHP outcome identification number(s): 094109802.3.5

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, LPDS intends to improve its all-cause 30-day readmission rate by at least 2.5% over the DY 4 measurement.

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-3.1: All-cause 30-day readmission rate—2.5% improvement over DY3
- DY5:
  - IT-3.1: All-cause 30-day readmission rate—5% improvement over DY3

Rationale:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving care coordination through the use of electronic medical records and computerized provider order entry systems. A measurable reduction in LPDS's all-cause 30-day readmission rate will indicate that LPDS has made progress towards these goals. In order to record this reduction, LPDS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

$2,023,888. In determining the value of this outcome measure, LPDS considered the extent to which a reduction in the all cause 30 day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including

supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better discharge management and better records management to improve quality of care and thereby improve patient outcomes. The valuation of this outcome measure also takes into account the challenges that LPDS will face in realizing this improvement in the hospital setting.

094109802.3.5	*IT-3.1*	*All-Cause 30-Day Readmission Rate*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.2.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $239,034	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $277,071	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $444,603	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: 5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,063,180
Year 2 Estimated Outcome Amount: $239,034	Year 3 Estimated Outcome Amount: $277,071	Year 4 Estimated Outcome Amount: $444,603	Year 5 Estimated Outcome Amount: $1,063,180
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,023,888			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 094109802.3.6

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate. In DY 5, LPDS intends to improve its patient satisfaction scores by at least 5% over the DY 3 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—5% improvement over DY3

Rationale:

This Category 3 outcome is tied to LPDS's Outpatient Women's Services Expansion project (094109802.1.2), but LPDS expects that the outcome will be positively impacted by two additional related Category 1 or 2 projects: LPDS's Primary Care Physician Recruitment project (094109802.1.1), and LPDS's Evaluate Hospitalist Model project (094109802.2.3).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by LPDS's Primary Care Physician Recruitment project (094109802.1.1) and Outpatient Women's Services Expansion project (094109802.1.2), and LPDS expects to see an improvement in patient satisfaction as a result of the associated Category 1 projects—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information.

Another challenge stemming from El Paso's lack of primary care capacity is the overburdening of existing primary care physicians, meaning that these physicians often do not see inpatients in a timely fashion. As a result, inpatient care is less coordinated and effective than it could be. This challenge will be addressed by LPDS's Evaluate Hospitalist Model project (094109802.2.3), and LPDS expects to see an improvement in patient satisfaction as a result of the associated Category 2 project—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information, and patients' rating of how well their doctors communicate.

Outcome Measure Valuation:

$1,686,573. In determining the value of this outcome measure, LPDS considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether LPDS's related Category 1 and 2 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges that LPDS will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

094109802.3.6	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.1.3*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $199,195	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $230,893	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $370,502	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $885,984
Year 2 Estimated Outcome Amount: $199,195	Year 3 Estimated Outcome Amount: $230,893	Year 4 Estimated Outcome Amount: $370,502	Year 5 Estimated Outcome Amount: $885,984
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,686,573			

95781

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 094109802.3.7

Performing Provider Name/TPI: HCA Las Palmas Del Sol / TPI: 094109802

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate. In DY 5, LPDS intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—5% improvement over DY3

Rationale:

This Category 3 outcome is tied to LPDS's Evaluate Hospitalist Model project (094109802.2.3), but LPDS expects that the outcome will be positively impacted by two additional related Category 1 or 2 projects: LPDS's Primary Care Physician Recruitment project (094109802.1.1), and LPDS's Outpatient Women's Services Expansion project (094109802.1.2).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by LPDS's Primary Care Physician Recruitment project (094109802.1.1) and Outpatient Women's Services Expansion project (094109802.1.2), and LPDS expects to see an improvement in patient satisfaction as a result of the associated Category 1 projects—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information.

Another challenge stemming from El Paso's lack of primary care capacity is the overburdening of existing primary care physicians, meaning that these physicians often do not see inpatients in a timely fashion. As a result, inpatient care is less coordinated and effective than it could be. This challenge will be addressed by LPDS's Evaluate Hospitalist Model project (094109802.2.3), and LPDS expects to see an improvement in patient satisfaction as a result of the associated Category 2 project—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information, and patients' rating of how well their doctors communicate.

Outcome Measure Valuation:

$1,574,135. In determining the value of this outcome measure, LPDS considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether LPDS's related Category 1 and 2 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges that LPDS will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

094109802.3.7	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.2.3*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $185,915	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $215,500	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $345,802	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $826,918
Year 2 Estimated Outcome Amount: $185,915	Year 3 Estimated Outcome Amount: $215,500	Year 4 Estimated Outcome Amount: $345,802	Year 5 Estimated Outcome Amount: $826,918
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,574,135			

Title of Outcome Measure (Improvement Target): IT-3.2: Congestive Heart Failure 30-Day Readmission Rate

Unique RHP outcome identification number(s): 094109802.3.8

Outcome Measure Description:
To achieve improvement under this metric, LPDS will engage in project planning during DY 2. In DY 3, LPDS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, LPDS intends to improve its congestive heart failure 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, LPDS intends to improve its congestive heart failure 30-day readmission rate by at least 5% over the DY 3 measurement.

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-3.2: Congestive heart failure 30-day readmission rate—2.5% improvement over DY3
- DY5:
  - IT-3.2: Congestive heart failure 30-day readmission rate—5% improvement over DY3

Rationale:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization for congestive heart failure patients can be reduced when a hospital implements standardized, evidence-based models of chronic care for patients at risk of congestive heart failure, thereby supporting better management of patients' chronic cardiac conditions. A measurable reduction in LPDS's congestive heart failure 30-day readmission rate will indicate that LPDS has made progress towards these goals. In order to record this reduction, LPDS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

$2,023,888. In determining the value of this outcome measure, LPDS considered the extent to which a reduction in the congestive heart failure 30-day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the

Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of a standardized chronic care model to improve quality of care and thereby improve patient outcomes for patients at risk for congestive heart failure. The valuation of this outcome measure also takes into account the challenges that LPDS will face in realizing this improvement in the hospital setting.

094109802.3.8	*IT-3.2*	*Congestive Heart Failure 30-Day Readmission Rate*	
HCA Las Palmas Del Sol			*094109802*
Related Category 1 or 2 Projects:	*094109802.2.4*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $239,034	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $277,071	**Outcome Improvement Target 1** [IT-3.2]: Congestive heart failure 30-day readmission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $444,603	**Outcome Improvement Target 2** [IT-3.2]: Congestive heart failure 30-day readmission rate. Improvement Target: 2.5% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,063,180
Year 2 Estimated Outcome Amount: $239,034	Year 3 Estimated Outcome Amount: $277,071	Year 4 Estimated Outcome Amount: $444,603	Year 5 Estimated Outcome Amount: $1,063,180
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,023,888			

95783

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 130601104.3.1

Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 196829901

Outcome Measure Description:
To achieve improvement under this metric, Providence will engage in project planning during DY 2. In DY 3, Providence will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Providence intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate; (3) patients' rating of doctor access to specialist. In DY 5, Providence intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY4

Rationale:

This Category 3 outcome is tied to Providence's Expand Primary Care Access project (130601104.1.1), but Providence expects that the outcome will be positively impacted by two additional related Category 1 projects: Providence's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), and Providence's Expand Specialty Care Capacity project (130601104.1.3).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be

addressed by Providence's Expand Primary Care Access project (130601104.1.1), and Providence expects to see an improvement in patient satisfaction as a result.

Another challenge which El Paso faces to a greater extent than other regions of the state is the challenge of providing culturally competent care to the region's large Hispanic patient population. A deficiency of proper, culturally-aware communication by physicians, hospital staff, and other providers will result in lower levels of patient satisfaction. This challenge will be addressed by Providence's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), and Providence expects to see an improvement in patient satisfaction as a result.

Finally, the El Paso area must address the challenges presented by the serious regional lack of specialty care capacity. Prompt access to specialty care will make it possible for patients to better manage their chronic health problems, resulting in better utilization of the resources available in the El Paso community of providers, and less utilization of expensive and inefficient healthcare sites such as Emergency Departments. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Providence's Expand Specialty Care Capacity project (130601104.1.3), and Providence expects to see an improvement in patient satisfaction as a result.

Outcome Measure Valuation:

$2,045,464. In determining the value of this outcome measure, Providence considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Providence's related Category 1 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges which Providence will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

Tenet plans to implement a similar Category 3 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.3.1	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Providence Memorial Hospital			*130601104*
Related Category 1 or 2 Projects:	*130601104.1.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $241,582	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $280,025	**Outcome Improvement Target 1** [IT-3.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $449,342	**Outcome Improvement Target 2** [IT-3.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $1,074,514
Year 2 Estimated Outcome Amount: $241,582	Year 3 Estimated Outcome Amount: $280,025	Year 4 Estimated Outcome Amount: $449,342	Year 5 Estimated Outcome Amount: $1,074,514
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,045,464			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 130601104.3.2

Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 130601104

Outcome Measure Description:
To achieve improvement under this metric, Providence will engage in project planning during DY 2. In DY 3, Providence will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Providence intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate; (3) patients' rating of doctor access to specialist. In DY 5, Providence intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY4

Rationale:

This Category 3 outcome is tied to Providence's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), but Providence expects that the outcome will be positively impacted by two additional related Category 1 projects: Providence's Expand Primary Care Access project (130601104.1.1), and Providence's Expand Specialty Care Capacity project (130601104.1.3).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Providence's Expand Primary Care Access project (130601104.1.1), and Providence expects to see an improvement in patient satisfaction as a result.

Another challenge which El Paso faces to a greater extent than other regions of the state is the challenge of providing culturally competent care to the region's large Hispanic patient population. A deficiency of proper, culturally-aware communication by physicians, hospital staff, and other providers will result in lower levels of patient satisfaction. This challenge will be addressed by Providence's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), and Providence expects to see an improvement in patient satisfaction as a result.

Finally, the El Paso area must address the challenges presented by the serious regional lack of specialty care capacity. Prompt access to specialty care will make it possible for patients to better manage their chronic health problems, resulting in better utilization of the resources available in the El Paso community of providers, and less utilization of expensive and inefficient healthcare sites such as Emergency Departments. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Providence's Expand Specialty Care Capacity project (130601104.1.3), and Providence expects to see an improvement in patient satisfaction as a result.

Outcome Measure Valuation:

$1,125,005. In determining the value of this outcome measure, Providence considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Providence's related Category 1 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges which Providence will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

Tenet plans to implement a similar Category 3 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.3.2	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Providence Memorial Hospital			*130601104*
Related Category 1 or 2 Projects:	*130601104.1.2*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $132,870	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $154,014	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $247,138	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $590,983
Year 2 Estimated Outcome Amount: $132,870	Year 3 Estimated Outcome Amount: $154,014	Year 4 Estimated Outcome Amount: $247,138	Year 5 Estimated Outcome Amount: $590,983
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,125,005			

94553

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 130601104.3.3

Outcome Measure Description:
To achieve improvement under this metric, Providence will engage in project planning during DY 2. In DY 3, Providence will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Providence intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate; (3) patients' rating of doctor access to specialist. In DY 5, Providence intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY3
- DY5:
    - IT-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY4

Rationale:

This Category 3 outcome is tied to Providence's Expand Specialty Care Capacity project (130601104.1.3), but Providence expects that the outcome will be positively impacted by two additional related Category 1 projects: Providence's Expand Primary Care Access project

(130601104.1.1), Providence's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Providence's Expand Primary Care Access project (130601104.1.1), and Providence expects to see an improvement in patient satisfaction as a result.

Another challenge which El Paso faces to a greater extent than other regions of the state is the challenge of providing culturally competent care to the region's large Hispanic patient population. A deficiency of proper, culturally-aware communication by physicians, hospital staff, and other providers will result in lower levels of patient satisfaction. This challenge will be addressed by Providence's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), and Providence expects to see an improvement in patient satisfaction as a result.

Finally, the El Paso area must address the challenges presented by the serious regional lack of specialty care capacity. Prompt access to specialty care will make it possible for patients to better manage their chronic health problems, resulting in better utilization of the resources available in the El Paso community of providers, and less utilization of expensive and inefficient healthcare sites such as Emergency Departments. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Providence's Expand Specialty Care Capacity project (130601104.1.3), and Providence expects to see an improvement in patient satisfaction as a result.

Outcome Measure Valuation:

$1,636,371. In determining the value of this outcome measure, Providence considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Providence's related Category 1 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges which Providence will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

Tenet plans to implement a similar Category 3 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.3.3	*3.IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Providence Memorial Hospital			*130601104*
Related Category 1 or 2 Projects:	*130601104.1.3*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $193,266	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $224,020	**Outcome Improvement Target 1** [IT-3.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $359,474	**Outcome Improvement Target 2** [IT-3.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $859,612
Year 2 Estimated Outcome Amount: $193,266	Year 3 Estimated Outcome Amount: $224,020	Year 4 Estimated Outcome Amount: $359,474	Year 5 Estimated Outcome Amount: $859,612
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,636,371			

Title of Outcome Measure (Improvement Target): IT-3.1: All-Cause 30-Day Readmission Rate

Unique RHP outcome identification number(s): 130601104.3.4

Performing Provider Name/TPI: Providence Memorial Hospital / TPI: 130601104

Outcome Measure Description:
To achieve improvement under this metric, Providence will engage in project planning during DY 2. In DY 3, Providence will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Providence intends to improve its all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, Providence intends to improve its all-cause 30-day readmission rate by at least 4% over the DY3 measurement.

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-3.1: All-cause 30-day readmission rate—2.5% improvement over DY3
- DY5:
    - IT-3.1: All-cause 30-day readmission rate— 4% improvement over DY3

Rationale:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings. A measurable reduction in Providence's all-cause 30-day readmission rate will indicate that Providence has made progress towards these goals. In order to record this reduction, Providence must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

$1,636,371. In determining the value of this outcome measure, Providence considered the extent to which a reduction in the all cause 30 day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this outcome measure also takes into account the challenges that Providence will face in realizing this improvement in the hospital setting.

Tenet plans to implement a similar Category 3 project at its Sierra Providence East Medical Center location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

130601104.3.4	*IT-3.1*	*All-Cause 30-Day Readmission Rate*	
Providence Memorial Hospital			*130601104*
Related Category 1 or 2 Projects:	*130601104.2.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $193,266	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $224,020	**Outcome Improvement Target 1** [IT-3.1]: All-cause 30-day readmission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $359,474	**Outcome Improvement Target 2** [IT-3.1]: All-cause 30-day readmission rate. Improvement Target: 4% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $859,612
Year 2 Estimated Outcome Amount: $193,266	Year 3 Estimated Outcome Amount: $224,020	Year 4 Estimated Outcome Amount: $359,474	Year 5 Estimated Outcome Amount: $859,612
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,636,371			

94548

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 196829901.3.1

Performing Provider Name/TPI: Sierra Providence East Medical Center / TPI: 196829901

Outcome Measure Description:
To achieve improvement under this metric, Sierra East will engage in project planning during DY 2. In DY 3, Sierra East will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Sierra East intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate; (3) patients' rating of doctor access to specialist. In DY 5, Sierra East intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY4

Rationale:

This Category 3 outcome is tied to Sierra East's Expand Primary Care Access project (130601104.1.1), but Sierra East expects that the outcome will be positively impacted by two additional related Category 1 projects: Sierra East's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), and Sierra East's Expand Specialty Care Capacity project (130601104.1.3).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be

addressed by Sierra East's Expand Primary Care Access project (196829901.1.1), and Sierra East expects to see an improvement in patient satisfaction as a result.

Another challenge which El Paso faces to a greater extent than other regions of the state is the challenge of providing culturally competent care to the region's large Hispanic patient population. A deficiency of proper, culturally-aware communication by physicians, hospital staff, and other providers will result in lower levels of patient satisfaction. This challenge will be addressed by Sierra East's Enhance Interpretation Services and Culturally Competent Care project (196829901.1.2), and Sierra East expects to see an improvement in patient satisfaction as a result.

Finally, the El Paso area must address the challenges presented by the serious regional lack of specialty care capacity. Prompt access to specialty care will make it possible for patients to better manage their chronic health problems, resulting in better utilization of the resources available in the El Paso community of providers, and less utilization of expensive and inefficient healthcare sites such as Emergency Departments. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Sierra East's Expand Specialty Care Capacity project (196829901.1.3), and Sierra East expects to see an improvement in patient satisfaction as a result.

Outcome Measure Valuation:

$1,148,423. In determining the value of this outcome measure, Sierra East considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Sierra East's related Category 1 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges which Sierra East will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

Tenet plans to implement a similar Category 3 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196829901.3.1	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Sierra Providence East Medical Center			*196829901*
Related Category 1 or 2 Projects:	*196829901.1.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $135,636	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $157,220	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $252,283	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $603,285
Year 2 Estimated Outcome Amount: $135,636	Year 3 Estimated Outcome Amount: $157,220	Year 4 Estimated Outcome Amount: $252,283	Year 5 Estimated Outcome Amount: $603,285
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,148,423			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 196829901.3.2

Performing Provider Name/TPI: Sierra Providence East Medical Center (Sierra East) / TPI: 196829901

Outcome Measure Description:
To achieve improvement under this metric, Sierra East will engage in project planning during DY 2. In DY 3, Sierra East will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Sierra East intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate; (3) patients' rating of doctor access to specialist. In DY 5, Sierra East intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY3
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY4

Rationale:

This Category 3 outcome is tied to Sierra East's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2), but Sierra East expects that the outcome will be positively impacted by two additional related Category 1 projects: Sierra East's Expand Primary Care Access project (130601104.1.1), and Sierra East's Expand Specialty Care Capacity project (130601104.1.3).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be

addressed by Sierra East's Expand Primary Care Access project (196829901.1.1), and Sierra East expects to see an improvement in patient satisfaction as a result.

Another challenge which El Paso faces to a greater extent than other regions of the state is the challenge of providing culturally competent care to the region's large Hispanic patient population. A deficiency of proper, culturally-aware communication by physicians, hospital staff, and other providers will result in lower levels of patient satisfaction. This challenge will be addressed by Sierra East's Enhance Interpretation Services and Culturally Competent Care project (196829901.1.2), and Sierra East expects to see an improvement in patient satisfaction as a result.

Finally, the El Paso area must address the challenges presented by the serious regional lack of specialty care capacity. Prompt access to specialty care will make it possible for patients to better manage their chronic health problems, resulting in better utilization of the resources available in the El Paso community of providers, and less utilization of expensive and inefficient healthcare sites such as Emergency Departments. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Sierra East's Expand Specialty Care Capacity project (196829901.1.3), and Sierra East expects to see an improvement in patient satisfaction as a result.

Outcome Measure Valuation:

$631,633. In determining the value of this outcome measure, Sierra East considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Sierra East's related Category 1 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges which Sierra East will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

Tenet plans to implement a similar Category 3 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196829901.3.2	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Sierra Providence East Medical Center			*196829901*
Related Category 1 or 2 Projects:	*196829901.1.2*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $74,600	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $86,471	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $138,755	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $331,807
Year 2 Estimated Outcome Amount: $74,600	Year 3 Estimated Outcome Amount: $86,471	Year 4 Estimated Outcome Amount: $138,755	Year 5 Estimated Outcome Amount: $331,807
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $631,633			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 196822901.3.3

Outcome Measure Description:
To achieve improvement under this metric, Sierra East will engage in project planning during DY 2. In DY 3, Sierra East will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Sierra East intends to improve its patient satisfaction scores by at least 2.5% over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate; (3) patients' rating of doctor access to specialist. In DY 5, Sierra East intends to improve its patient satisfaction scores by at least 2.5% over the DY 4 measurement in the same areas.

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-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY3
- DY5:
    - IT-6.1: Percent improvement over baseline of patient satisfaction scores—patient's rating of whether patient is getting timely care, appointments, and information—2.5% improvement over DY4

Rationale:

This Category 3 outcome is tied to Sierra East's Expand Specialty Care Capacity project (130601104.1.3), but Sierra East expects that the outcome will be positively impacted by two additional related Category 1 projects: Sierra East's Expand Primary Care Access project

(130601104.1.1), and Sierra East's Enhance Interpretation Services and Culturally Competent Care project (130601104.1.2).

The El Paso area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Sierra East's Expand Primary Care Access project (196822901.1.1), and Sierra East expects to see an improvement in patient satisfaction as a result.

Another challenge which El Paso faces to a greater extent than other regions of the state is the challenge of providing culturally competent care to the region's large Hispanic patient population. A deficiency of proper, culturally-aware communication by physicians, hospital staff, and other providers will result in lower levels of patient satisfaction. This challenge will be addressed by Sierra East's Enhance Interpretation Services and Culturally Competent Care project (196822901.1.2), and Sierra East expects to see an improvement in patient satisfaction as a result.

Finally, the El Paso area must address the challenges presented by the serious regional lack of specialty care capacity. Prompt access to specialty care will make it possible for patients to better manage their chronic health problems, resulting in better utilization of the resources available in the El Paso community of providers, and less utilization of expensive and inefficient healthcare sites such as Emergency Departments. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Sierra East's Expand Specialty Care Capacity project (196822901.1.3), and Sierra East expects to see an improvement in patient satisfaction as a result.

Outcome Measure Valuation:

$918,738. In determining the value of this outcome measure, Sierra East considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Sierra East's related Category 1 projects are successful in their goals. The valuation of this outcome measure also takes into account the challenges which Sierra East will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

Tenet plans to implement a similar Category 3 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196822901.3.3	*3.IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Sierra Providence East Medical Center			*196822901*
Related Category 1 or 2 Projects:	*196822901.1.3*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $108,509	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $125,776	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $201,826	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 2.5% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $482,628
Year 2 Estimated Outcome Amount: $108,509	Year 3 Estimated Outcome Amount: $125,776	Year 4 Estimated Outcome Amount: $201,826	Year 5 Estimated Outcome Amount: $482,628
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $918,738			

94571

Title of Outcome Measure (Improvement Target): IT-3.1: All-Cause 30-Day Readmission Rate

Unique RHP outcome identification number(s): 196829901.3.4

Performing Provider Name/TPI: Sierra Providence East Medical Center / TPI: 196829901

Outcome Measure Description:
To achieve improvement under this metric, Sierra East will engage in project planning during DY 2. In DY 3, Sierra East will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Providence intends to improve its all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, Sierra East intends to improve its all-cause 30-day readmission rate by at least 4% over the DY3 measurement.

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-3.1: All-cause 30-day readmission rate—2.5% improvement over DY3
- DY5:

  IT-3.1: All-cause 30-day readmission rate— 4% improvement over DY3

Rationale:
According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings. A measurable reduction in Sierra East's all-cause 30-day readmission rate will indicate that Sierra East has made progress towards these goals. In order to record this reduction, Sierra East must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

$918,738. In determining the value of this outcome measure, Sierra East considered the extent to which a reduction in the all cause 30 day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this outcome measure also takes into account the challenges that Sierra East will face in realizing this improvement in the hospital setting.

Tenet plans to implement a similar Category 3 project at its Providence Memorial Hospital location, serving a different geographic area of the city. The disparity in valuation between this Providence project and the similar Sierra East project is due to the fact that Providence is a much larger facility than Sierra East (with 508 beds, compared to 110 at Sierra East) and accounts for 270% more Medicaid and uninsured days than Sierra East.

196829901.3.4	*IT-3.1*	*All-Cause 30-Day Readmission Rate*	
Sierra Providence East Medical Center			*196829901*
Related Category 1 or 2 Projects:	*196829901.2.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $108,509	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $125,776	**Outcome Improvement Target 1** [IT-3.1]: All-cause 30-day readmission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $201,826	**Outcome Improvement Target 2** [IT-3.1]: Al-cause 30-day readmission rate. Improvement Target: 4% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $482,628
Year 2 Estimated Outcome Amount: $108,509	Year 3 Estimated Outcome Amount: $125,776	Year 4 Estimated Outcome Amount: $201,826	Year 5 Estimated Outcome Amount: $482,628
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $918,738			

94552

Title of Outcome Improvement Measure: IT-11.6 *Other Outcome Improvement Target: Time to Ophthalmologist Evaluation*

RHP Performing Provider / TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number: 084597603.3.1

Related Category 1 or 2 Project: 084597603.1.1

Outcome Measure Description: We propose to measure a unique outcome measure that represents time required for a Hispanic patient with Diabetes to be evaluated by an ophthalmologist following the referral from a therapeutic optometrist. This metric completes our assessment of access to ocular care and complements 084597603.3.2 which reflects our success in screening Hispanic patients with Diabetes for eye disease.

The criteria we will use to identify these patients are:

1. Seen by a performing provider therapeutic optometrist
2. Self-reported ethnicity or race is Hispanic based on demographics in our scheduling system
3. Documentation of referral to a performing provider ophthalmologist
4. Elapsed days between the date of optometrist and ophthalmologist appointment

Process Milestones:

DY2

- P-1 Program Planning – provider and staff education, development of tracking and reporting tools, design IT reporting tool

DY3

- P-2 Baseline data: We will collect baseline data on the time to evaluation as defined above.

Improvement Milestones:

DY4 I

- T-11.6: We will reduce the for time to evaluation by 20% compared to the baseline in DY3

DY5

- IT-11.6: We will reduce the time to evaluation by 40% compared to the time in DY3.

These data will be collected from EMR, scheduling system software and the survey instrument

Rationale: P-1 and P-2 were chosen because at this point we do not collect this data in any form at this time. These reflect the steps necessary to inform our care team of the importance of this issue, and to develop the infrastructure to capture this data, and to redesign appointment templates to meet this need

We chose improvement targets based upon what we consider reasonable incremental improvements reflecting increased provider capacity and better referral and schedule management.

Value: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.1	*3.IT-11.6*	*Other Outcome Improvement Target*	
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 1 or 2 Projects:	084597603.1.1		
Starting Point/Baseline:	*To 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-2]* Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Build the necessary infrastructure to provide the proper environment and support needed for the accomplishment of milestones and targets. Goals: • Plan activities and implementation tables • Provide proper training to staff and faculty • Crease appropriate EMR structure • Provide appropriate IT support structure • Create report for data collections Process Milestone 1 Estimated Incentive Payment:$21,119	**Process Milestone 2** [*P-2] Establish baseline data* Metric 1 [*P-2.1*]: Collect baseline data rate for : Time to Ophthalmologist Evaluation Goal: Determine baseline rate for IT-11.6 in patients assigned to ophthalmology. Data Source: EMR, Registry Report Process Milestone 2 Estimated Incentive Payment: $48,959	**Outcome Improvement Target 1** [IT-11.6]: Other Outcome Improvement Target: Time to Ophthalmologist Evaluation Goal: Reduce the for time to evaluation by 20% compared to the baseline in DY3 Data Source: EMR, Electronic Scheduling systems Outcome Improvement Target 1 Estimated Incentive Payment: $52,375	**Outcome Improvement Target 2** [IT-11.6]: Other Outcome Improvement Target: Time to Ophthalmologist Evaluation Goal: Reduce the time to evaluation by 40% compared to baseline in DY3 Data Source: EMR, Electronic Scheduling systems Outcome Improvement Target 2 Estimated Incentive Payment: $113,858 .
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount: : $48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount: $113,858
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**: $236,311***			

Title of Outcome Improvement Measure: IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity.

RHP Performing Provider / TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number: 084597603.3.2

Related Category 1 or 2 Project: 084597603.1.1

Outcome Measure Description:

We propose to utilize the RAND VSQ-9 Patient Satisfaction Survey (attachment A) to measure patient satisfaction. The survey population will be limited to patients who self-identify as Hispanic. The Performing Provider has experience with Press Ganey survey instruments within the past decade. Overall response rates were very low, in the single digit range. We believe there are a series of structural issues that drove this poor response. Our population is heavily enriched in low income patients. Challenges related to incorrect and changing addresses, and the comprehension level required to complete more complex survey tools such as CG-CAHPS limits response rates. Also, our Region shares an international border with Juarez, Mexico. We believe that many patients in our population choose not to respond to such a survey, not fully understanding the importance of their response, and not recognizing that their participation has no impact on their residence in the region. For these reasons we believe a short survey, administered at the point of service, represents the best option to obtain meaningful data across a wide patient representation. The RAND survey has been validated for accuracy and validity (1) and contains questions which focus on high level patient satisfaction domains and will provide actionable information to improve our regional care delivery. We acknowledge that this survey will not provide results which are directly comparable to CG-CAHPS on a national level. They will, however, provide valid, actionable data on which to assess the impact of this project in Region 15.

Process Milestones:

DY2

- P-1 Program Planning – provider and staff education, development of tracking and reporting tools, design access plan

DY3

- P-2 Collect baseline data on the number of unique patients with diabetes, self-identified as Hispanic race or ethnicity, who receive a diabetic eye exam as defined in OD-1, IT-1.11. This data will be collected from EMR, Registry, and scheduling systems

Improvement Milestones:

DY4

- IT-11.4: The percent of patients reporting a score of 80 or higher will increase by 10% from the baseline in DY3 OR be 70% or greater

DY5

- IT-11.4: The percent of patients reporting a score of 80 or higher will increase by 10% from the rate in DY3 OR be 75% or greater

These data will be collected from EMR, scheduling system software and the survey instrument.

Rationale: P-1 and P-2 were chosen because at this point we do not collect patient satisfaction data in any form across our enterprise. These reflect the steps necessary to inform our care team of the importance of this issue, and to develop the infrastructure to capture this data.

Patient satisfaction is an essential component of holistic care and particularly important in a population who may feel disenfranchised. IT-11.4 directly measures this metric in a minority population.

Value: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

1. http://www.rand.org/health/surveys_tools/vsq9.html. Accessed September 29, 2012.

084597603.3.2	*3.IT-11.4*	Improve patient satisfaction	
TEXAS TECH HS CTR FAMILY MED			*752668018*
Related Category 1 or 2 Projects:	*084597603.1.1*		
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**.** Metric [P-1.1]: Complete planning process for capturing benchmark data. Engage IT and EMR support to design necessary reports. Train staff on the metric. Data Source: Implementation plan. Process Milestone 1 Estimated Incentive Payment:$21,119	**Process Milestone 2** [*P-2] : Establish Baseline Rates* Metric 1 [P-2.2]]: Establish baseline rate for compliance with 11.4 in the ophthalmology clinic. Target population will be all patients assigned to the clinic Goal: Determine baseline rate for IT-11.4 in patients assigned to clinic as based on patient satisfaction as measured by the RAND VSQ-9 survey tool. Data Source: EMR, RAND survey tool Rationale: Baseline data provide the basis to judge the impact of this project on patient satisfaction Process Milestone 2 Estimated Incentive Payment: $48,959	**Outcome Improvement Target 1** [IT-11.4]: Improve patient satisfaction and/or quality of life scores in target population with identified disparity Goal: The percent of patients reporting a score of 80 or higher will increase by 10% from the baseline in DY3 OR be 70% or greater Data Source: RAND survey tool Outcome Improvement Target 1 Estimated Incentive Payment: $52,375	**Outcome Improvement Target 2** [IT-11.4]: Improve patient satisfaction and/or quality of life scores in target population with identified disparity Goal: The percent of patients reporting a score of 80 or higher will increase by 10% from the rate in DY3 OR be 75% or greater Outcome Improvement Target 2 Estimated Incentive Payment:$113,858
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount: $48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount:$113,858
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:** $236,311*			

Title of Outcome Improvement Measure: IT-11.3 Improve utilization rates of clinical preventive services (diabetic eye exams) in Hispanic population with identified disparity

RHP Performing Provider / TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number: 084597603.3.3

Related Category 1 or 2 Project: 084597603.1.1

Outcome Measure Description: IT-11.3 Improve utilization rates of clinical preventive services (diabetic eye exams) in Hispanic population with identified disparity. We will use language identical to IT 1-12 limited to those patients who self-report ethnicity or race as Hispanic

Process Milestones:

DY2

- P-1 Program Planning – provider and staff education, development of tracking and reporting tools, design access plan

DY3

- P-2 Collect baseline data on the number of unique patients with diabetes, self-identified as Hispanic race or ethnicity, who receive a diabetic eye exam as defined in OD-1, IT-1.11. This data will be collected from EMR, Registry, and scheduling systems

Improvement Milestones:

DY4

- IT-11.3: The total number of patients self-reported as Hispanic, with a diagnoses of diabetes, who receive a screening eye exam by the performing provider will increase by 25%from DY3

DY5

- The total number of patients self-reported as Hispanic, with a diagnoses of diabetes, who receive a screening eye exam by the performing provider will increase by 40% from DY3

These data will be collected from our appointment scheduling system and our EMR

Rationale: A major manifestation of the profound ocular care provider shortage in Region 15 is the low compliance with recommendations for annual eye exams in patients with diabetes. The importance of this exam is underscored by it being a core HEDIS marker. We strongly suspect that Hispanics in our population, a significant number of whom are indigent or have Medicaid, will be disproportionally affected by this by ocular care provider shortage. In addition, the lack of access to primary care creates more barriers to receiving this screening exam. P-1 and P-2 were chosen because we have no mechanism to objectively confirm this impression, and these will provide the framework to measure improvements.

IT-11.3 was chosen to directly measure the impact this project, but also Regional efforts to improve access to primary care are having on Hispanic patients with diabetes in the Region. The improvements reflect aggressive targets reflecting our increased provider capacity.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objective.

084597603.3.3	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.*	
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 1 or 2 Projects:	*084597603.1.1*		
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] :* Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: [P-1.1] Build the necessary infrastructure to provide the proper environment and support needed for the accomplishment of milestones and targets. Goals: • Plan activities and implementation tables • Provide proper training to staff and faculty • Crease appropriate EMR structure • Provide appropriate IT support structure • Create report for data collections Process Milestone 1 Estimated Incentive Payment: $21,119	**Process Milestone 2** [*P-2] Establish Baseline Rates.* Metric 2[P-2.2] : Establish baseline rate for compliance with 11.3 in the Ophthalmology clinic. Target population will be all patients assigned to clinic. Goal: Determine baseline rate for the number of patients self-reported as Hispanic, with a diagnosis of diabetes, who receive a screening eye exam by the performing provider. This will be an annualized number based on the last 3 months of DY2 Data Source: EMR, Electronic Scheduling systems Rationale: These data will provide a critical benchmark to measure the impact of this program Process Milestone 2 Estimated Incentive Payment: $48,959	Outcome Improvement Target 1 [IT-11.3] Improve utilization rates of clinical preventive services in target population with identified disparity. Goal: The total number of patients self-reported as Hispanic, with a diagnoses of diabetes, who receive a screening eye exam in DY4 by the performing provider will increase by 25% from DY3 Outcome Improvement Target 1 Estimated Incentive Payment: $52,375	Outcome Improvement Target 2 [IT-11.3:] Improve utilization rates of clinical preventive services in target population with identified disparity. Goal: The total number of patients self-reported as Hispanic, with a diagnoses of diabetes, who receive a screening eye exam by the performing provider will increase by 40% from DY3 Outcome Improvement Target 2 Estimated Incentive Payment: $ 113,858
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount: $48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount: $ 113,858

084597603.3.3	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.*	
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 1 or 2 Projects:	*084597603.1.1*		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:** $236,311*			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes care: BP control (<140/80mm Hg)

Unique RHP outcome identification number: 084597603.3.4

Related Category 1 or 2 Project: 084597603.1.2

Performing Provider / TBI TEXAS TECH HS CTR FAMILY MED / 084597603

Process Milestones:

DY2

- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY2

- P- 2 Establish baseline rates for compliance with IT-1.11. The target population will be all patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes.

DY4

- IT-1.11 The % of patients who meet the requirements of IT-1.11 in the Kenworthy Family Medicine Clinic will be 50%, OR increase by 10% from the baseline established in DY2

DY5

- The % of patients who meet the requirements of IT-1.11 in the Kenworthy Family Medicine Clinic will be 55%, OR increase by 10% from the rate established in DY3

Rationale: Our population suffers from a high prevalence of, and disproportionate impact from diabetes. Furthermore, our patient population is heavily represented by the uninsured or under-insured. Given the profound shortage of primary care providers in the Region, access to comprehensive primary care of diabetes in our population is extremely challenging. As such, we have made the decision to focus improvement targets in this project on markers of diabetes care. We believe the proposed targets reflect realistic and achievable targets.

Data to report this will be captured from the Registry, our EMR, and our electronic scheduling system

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if

any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.4	3.IT- 1.11	Diabetes care: BP control	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.2		
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 timelines and document implementation plans. Metric [P-1.1] Complete planning process for capturing benchmark data. Engage IT and EMR support to design necessary reports. Train staff on the metric. Goal: documentation of implementation plan and staff training. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $63,359	**Process Milestone 2** [*P-2*]: Establish baseline rates. Metric [P-2.1]: Establish baseline rate for compliance with IT-1.11 in the Kenworthy Family Medicine Clinic. Target population will be all patients assigned to the PCMH. Goal: Determine baseline rate for IT-1.11 in patients assigned to the PCMH at Kenworthy Family Medicine Data Source: EMR, Registry report. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $146,880	**Outcome Improvement Target1** [IT-1.11]: Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061 (Standalone measure) Outcome Improvement Target]: Goal: The % of patients who meet the requirements of IT-1.11 in the Kenworthy Family Medicine Clinic will be 50%, OR increase by 10% from the baseline established in DY2 Outcome Improvement Target 1: Estimated Incentive Payment: $157,128	**Outcome Improvement Target2** [IT-1.11]: Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061 (Standalone measure) Outcome Improvement Target]: Goal: The % of patients who meet the requirements of IT-1.11 in the Kenworthy Family Medicine Clinic will be 65%, OR increase by 10% from the rate established in DY4 Outcome Improvement Target 2: Estimated Incentive Payment: $341,577
Year 2 Estimated Outcome Amount: $63,359	Year 3 Estimated Outcome Amount: $146,880	Year 4 Estimated Outcome Amount: $157,128	Year 5 Estimated Outcome Amount: $341,577
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $708.944			

Title of outcome Improvement Project: IT-11.1 Improvement in Clinical Indicator in identified disparity group
Unique RHP outcome identification number: 084597603.3.5

Related Category 1 or 2 Project: 084597603.1.3

RHP Performing Provider: TEXAS TECH HS CTR FAMILY MED / 084597603

Outcome Measures Description:
IT-11.1 Improvement in Clinical Indicator in identified disparity group: Reduction in the re-occurrence rate of seizures in Hispanic patients with Epilepsy.
Process Milestones:
DY2

- 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 to capture baseline rates
- P-2 Establish baseline rates

Improvement Milestones:
DY4: TBD
DY5: TBD
Rationale:
The management of epilepsy in Hispanics presents unique challenges. Accessing care for this population is difficult[ix] for a variety of reasons to such an extent that the Institute of Medicine has noted the "unequal treatment" minorities are challenged with accessing care[x]. Within the Hispanic community, there is considerable misinformation on this condition[xi]. For example, Hispanics are nearly 8 times more likely to believe that a patient with epilepsy cannot hold a steady job or will die at a younger age than non-Hispanics. Eight percent of Hispanics in this study believed epilepsy was contagious or related to some kind of evil spirit or sins.

The outcome measure was selected considering that Hispanics with epilepsy usually have higher rates of generalist visits, ER care, and hospitalizations, and lower rates of specialist visits. In addition, Hispanics are more likely to have uncontrolled seizures, have side effects of medications, more frequent hospitalizations and a lower overall quality of life Begley et al; Epilepsia 2009 May; 50(5):1040-50. While these disparities are seen specific to the ethnic group it is also clear that the socioeconomic status influences the disparities

Given these disparities, a multi-disciplinary approach to the care of these patients is critical. We propose to use a measure of the reoccurrences, or break through seizures in Hispanic patients as a clinical outcome indicator. We will be working with providers and others involved in the care of these patients over DY2-3 to develop an appropriate definition for this metric, and to propose reasonable improvement metrics.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives

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[ix] Grisolia JS. Epilepsy of the borderlands: seizure disorders in US Latinos. Epilepsy Behav 2000;1:150–2.

[x] Smedley BD, Stith AY, Nelson AR, editors, for the Institute of Medicine (IOM). Unequal treatment: confronting racial and ethnic disparities in healthcare. Washington DC: National Academy Press; 2003.

[xi] Sirven J, et al; Que es la Epilepsia? Attitudes and knowledge of epilepsy by Spanish speaking adults in the United States. Epilepsy Behav 2005;7:259-65.

084597603.3.5	*3.IT-11-1*	Improvement in Clinical Indicator in identified disparity group	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.3		
Starting Point/Baseline:	*To 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-1] Project planning, engaging stakeholders, identify current capacity. Metric [P-1.1]: Complete and document project plan and training to track seizure reoccurrence rates as specified in DY3 Data Source: Project reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $63,358	**Process Milestone 2** [P-3]: Develop and test systems Metric [P-3.1]Test data collection systems. Goal: Demonstrate ability to capture baseline rate of seizure recurrence in Hispanic population cared for in performing provider's Department of Neurology. Data Source: Testing reports Process Milestone 2 Estimated Incentive Payment: $73,440 **Process Milestone 3 [P-2]** Establish baseline rates Metric [P-2.1] Baseline seizure reoccurrence In Hispanic population Goal: Capture and report baseline rates of Hispanic patients with two or more visits to PP neurologist in DY 1 or 2 with a diagnosis of epilepsy, who have suffered a seizure re-occurrence that requires either a visit to an urgent care clinic or emergency room, or an in-patient hospitalization. Data Source: EMR system, Patient reports.	**Outcome Improvement Target 1** [IT-11.1]: TBD Outcome Improvement Target 1 Estimated Incentive Payment*:* $157,128	**Outcome Improvement Target 2** [IT-11.1]: TBD Outcome Improvement Target 2 Estimated Incentive Payment*:* $341,575

084597603.3.5	*3.IT-11-1*	Improvement in Clinical Indicator in identified disparity group	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.3		
Starting Point/Baseline:	*To 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 3 Estimated Incentive Payment: $73,441		
Year 2 Estimated Outcome Amount: $63,358	Year 3 Estimated Outcome Amount: $146,881	Year 4 Estimated Outcome Amount: $157,128	Year 5 Estimated Outcome Amount: $341,575
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $708,942			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Name: The Impact of a Survivor's Program on Quality of Life among Predominately Hispanic Breast Cancer Survivors.

Performing Provide / TBI: TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP Outcome Number: 084597603.3.6

Related Category 1 or 2 Project: 084597603.1.4

Process Milestones:

DY2

- P-2: Establish baseline rates of Quality of Life for eligible patients as defined below.

DY3

- P -2: Establish baseline rates of Quality of Life for eligible patients as defined below.

DY4

- IT-10: 5045% of eligible patients, enrolled in DY2 will have an improved quality of life as defined below.

DY5

- IT-10: 50% of eligible patients, enrolled in DY3 will have an improved quality of life as defined below.

Outcome measure Description: The primary endpoint for our Category 3 milestones and metrics for this project will be improvements in the Quality of Life as assessed by a standardized assessment tool, the Health related SF-36 Survey. We will recruit two separate cohorts of patients: one in DY2 which completes the program in DY4, and one in DY3 will complete the program in DY5. 45% of patients in the cohort established in DY2 and 50% of the DY3 cohort will have meaningful improvements in quality of life,We will measure Quality of Life at entry in the program, every 6 months and at the completion of Year 1 and Year 2 in the survivorship care program. The survivors program is a rolling 2 year program. As such, we will report, in DY 4 on outcomes on quality of life, for patients enrolled in DY2, and in DY54 for patients enrolled in DY3 Lessons learned from the DY2 cohort should allow us to increase the success rate to 50% for the DY3 cohort. We will recruit a minimum of 60 patients in each cohort.

Rationale: The background related to Quality of Life in breast cancer survivors, as well as the potential disparate impact on Hispanic women, is well documented in our Category 1 narrative, and is incorporated by reference here.

IT-10 represents the measure of the impact of the survivors program on this population. We believe the services provided in the survivor's program will be found to be of value to most women who participate, and we intend to offer participation to every women with breast cancer

followed in the UBCC. Given the heterogeneity of cancers in terms of staging, current status of treatment, and impact of staging on outcome, it is important, for purposes of documenting improvement, to define a more homogeneous population. Consequently, we propose to include in the analysis of improvement of quality of life eligible patients as defined by:

1) Hispanic patients within 3 years of breast diagnosis;
2) stages I, II or III with no distant metastatic spread and who have completed surgery and treatment with chemotherapy and radiation therapy, and
3) have completed the survivor's program.

An eligible patient shall be defined as improved if:
1) their SF-36 score increases by 15% (1) from entry baseline at any subsequent point during their participation in the survivorship program, OR

2) their SF-36 score is normal (50 or greater) at any point during their participation in the survivorship program

1. Sandel L et al., Dance and Movement Program Improves Quality-of-Life Measures in Breast Cancer Survivors. Cancer Nursing, 24(4),2005

Value: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.6	3.IT-10.1	Quality of Life	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.4		
Starting Point/Baseline:	*To be determined in DY1 and DY2*		
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: Goal: We will establish baseline patient specific Quality of Life scores for eligible patients as defined in the accompanying narrative enrolled in DY2 Data Source: SF-36 Survey Process Milestone 1 Estimated Incentive Payment *(maximum amount):* 63,358	**Process Milestone 2** *P-2*] Establish baseline rates: Goal: We will establish baseline patient specific Quality of Life scores for eligible patients as defined in the accompanying narrative enrolled in DY2 Data Source: SF-36 Survey Process Milestone 2 Estimated Incentive Payment *(maximum amount): $*146,881	**Outcome Improvement Target 1** [IT-10.1]: **Quality of Life (standalone measure):** Goal: 45% of DY 2 cohort patients enrolled in and completing the program will have improved Quality of Life as defined in the category 3 narratives. Data Source: Survey data Outcome Improvement Target 1 Estimated Incentive Payment*:* $157,128	**Outcome Improvement Target 2** [IT-10.1]: **Quality of Life (standalone measure):** Goal.50% of DY 3 cohort patients enrolled in and completing the program will have improved Quality of Life as defined in the category 3 narratives. Data Source: Survey data Outcome Improvement Target 2 Estimated Incentive Payment*:* $341,575
Year 2 Estimated Outcome Amount: 63,358	Year 3 Estimated Outcome Amount: *$*146,881	Year 4 Estimated Outcome Amount: $157,128	Year 5 Estimated Outcome Amount: $341,575
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 708.942			

Title of Outcome Measure (Improvement Target): **IT 6.2 Other outcome improvement target**

RHP Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603
Unique RHP outcome identification number: 084597603.3.7

Related Category 1 or 2 Project: 084597603.1.5

Outcome Measures Description: Patient satisfaction as measured by the RAND VSQ-9 survey conducted at the time of the visit.

Process Milestones:
DY2:

- P-1 – Engage stakeholders, identify needed resources, determine timelines.

DY3

- P-2 – collect baseline data for patient satisfaction with general surgery services.

Improvement Milestones:
DY4

- IT – 6 the percent of patients reporting a score of 80 or higher will increase by 10% from the baseline in DY3 OR be 70% or greater

DY5

- IT – 6 the percent of patients reporting a score of 80 or higher will increase by 10% from the baseline in DY4 OR be 75% or greater.

Rationale: Process milestones P-1 and P-2 were chosen to develop the infrastructure to capture this metric at the point of care, and to establish a baseline. The improvements proposed in DY4 and DY5 reflect meaningful increases in patient satisfaction. These data will be captured from EMR, our patient scheduling system, and the survey tool.

Outcome Measure Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional

initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.7	**6. IT- 6.2**	Improve patient satisfaction	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.5		
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 stakeholder, identify IT solutions for survey, identify needed resources, determine implementation timeline an document implementation plan Data Source: Implementation Plan. Process Milestone 1 Estimated Incentive Payment:$63,358	**Process Milestone 2** [*P-2]: Establish baseline rate* Metric 1 [P-2.2 : Determine baseline rate for: Patient satisfaction as measured by the RAND VSQ-9 survey tool for general surgery patients. Data Source: RAND survey tool Rationale: Baseline data provide the basis to judge the impact of this project on patient satisfaction Process Milestone 2 Estimated Incentive Payment: $146,881	**Outcome Improvement Target 1** [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)* Goal: The percent of patients reporting a score of 80 or higher will increase by 10% from the baseline in DY3 OR be 70% or greater. Data Source: RAND survey tool Outcome Improvement Target 1 Estimated Incentive Payment: $157,128	**Outcome Improvement Target 2** [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)* Goal: The percent of patients reporting a score of 80 or higher will increase by 10% from the baseline in DY3 OR be 75% or greater. Data Source: RAND survey tool Outcome Improvement Target 2 Estimated Incentive Payment: $341,575
Year 2 Estimated Outcome Amount: $63,358	Year 3 Estimated Outcome Amount: $146,881	Year 4 Estimated Outcome Amount: $157,128	Year 5 Estimated Outcome Amount: :$341,575
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:** $708.942*			

Title of Outcome Measure (Improvement Target) IT-11.1 The impact of expanding access to Health Periodicity Exams on immunization status in a Hispanic population

Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 0*84597603*

Unique RHP outcome identification number: 084597603.3.8

Related Category 1 or 2 Project: 084597603.1.6

Outcomes IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure*) - *% of children, who self-report ethnicity as Hispanic, who are current in their Tdap booster status at the completion of receiving a health maintenance examination in the acute care setting.* A child is considered up to date, if they 1) receive the vaccination at the time of visit 2) have documentation in our medical record of having received the vaccination or 3) a query of the statewide immunization registry provides documentation of the patient having received the vaccination.

We will use the last 3-6 months of DY2 as an annualized baseline rate for this metric

Process Milestones

DY2

- P-1 Project planning

DY3

- P-3 Develop and test reporting system to capture required immunization history and provide status reports.
- P-2 establish baseline rates for current immunization status

DY4

- IT-11.1 The percent of Hispanic children current in booster Tdap will be 50% or greater.

DY5

- IT-11.1 The percent of Hispanic children current in booster Tdap will be 60% or greater

Rationale: The purpose of this project is to address a well-documented problem of under-utilization of preventative healthcare services for children, by addressing potential core reasons for this underutilization. Our population is almost exclusively Hispanic (93%) and low income. Eighty-nine percent of the patients we treat in our after-hours acute care walk in clinic are uninsured, or have Medicaid, or CHIP as a payor. Immunization status is a well-recognized indicator of health status. Moreover, El Paso County is experiencing an epidemic of pertussis, making the booster immunization all the more important.

We can not provide an absolute number of patients who will receive this vaccine since it a function of how many children in the eligible age range access services, and don't already have the vaccine from another source

Outcome Measure Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.8	*IT-11.1*	Improvement in Clinical Indicator in identified disparity group	
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 1 or 2 Projects::	084597603.1.6		
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] Participate in semi-annual face-to-face meetings or seminars organized by the RHP Metric [P-1.1]:: We will establish a multi-disciplinary team including providers, staff, IT and EMR support to develop training materials and reporting mechanisms Data Source: Project Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $63,358	**Process Milestone 2** [P-3]: Develop and test data systems Metric [P-3.1] We will develop and test data systems to capture required immunization history and to develop reports Data Source: Examples of reports. Process Milestone 2 Estimated Incentive Payment: $73,440 **Process Milestone 3[P-2]** Establish baseline rates Metric [P-2.1] Establish baseline rates for current immunization status utilizing the existing walk in clinic population Data Source: registry reports Process Milestone 3 Estimated Incentive Payment: $73,441	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in Identified disparity group. Improvement Target: The percent of Hispanic children current in booster Tdap will be 50% or greater Data Source: Registry report Outcome Improvement Target 1 Estimated Incentive Payment*:* $157,128	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in Identified disparity group. Improvement Target: The percent of Hispanic children current in booster Tdap will be 60% or greater Data Source: Registry report Outcome Improvement Target 1 Estimated Incentive Payment*:* $341,575

084597603.3.8	*IT-11.1*	Improvement in Clinical Indicator in identified disparity group	
TEXAS TECH HS CTR FAMILY MED			TPI 084597603
Related Category 1 or 2 Projects::	084597603.1.6		
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)**
Year 2 Estimated Outcome Amount: $63,358	Year 3 Estimated Outcome Amount: $146,881	Year 4 Estimated Outcome Amount: $157,128	Year 5 Estimated Outcome Amount: $341,575
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $708,942			

Title of Outcome Improvement Target: IT – 14.4 Percent of graduates who practice in a HPSA or MUA

Unique RHP outcome identification number: 084597603.3.9

Related Category 1 or 2 Project: 084597603.1.7

Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Outcome Measure Description:

IT – 14.4 Percent of graduates who practice in a HPSA or MUA

Process Milestones:

DY2

- P-1: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3

- *P-2*: determine the baseline rate. The first graduation from this program will occur in DY4 (1 fellow)

DY4

- IT- 14.4: Zero percent of graduates will meet metric

DY5

- IT- 14.4: 50% percent of graduates will meet metric

Rationale: P-1 and P-2 reflects the steps necessary to develop the resources to report on an improvement target and establish the baseline rate. Our first graduate from this fellowship will be in DY4, and at end of DY5 there will be two graduates.

Outcome Measure Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional

initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.9	*3.IT-14.4*	Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.7		
Starting Point/Baseline:	*TO be determined inDY3*		
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: Implementation plan Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $21,119	**Process Milestone 2** [*P-2*]: Establish baseline rate: Metric [P-2.1]: Determine baseline rate. Goal: We will determine the baseline for the selected improvement target. Data Source: EMR, Scheduling system Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $48,959	**Outcome Improvement Target 1** TBD Improvement Target: [IT-14.4]: Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Goal: Zero percent of graduates will meet metric Data Source: Systematic Survey Outcome Improvement Target 1: Estimated Incentive Payment *(maximum amount):* $52,375	**Outcome Improvement Target 2** TBD Improvement Target: [IT-14.4]: Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Goal: 50% percent of graduates will meet metric Data Source: Systematic Survey Outcome Improvement Target 2: Estimated Incentive Payment *(maximum amount):* $60,000
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount: $48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount: $60,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $182,453			

Title of Outcome Improvement Target: . IT- 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number: 084597603.3.10

Related Category 1 or 2 Project: 084597603.1.7

Outcome Measure Description:

IT- 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Process Milestones:

DY2
P-1: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

-

DY3

- *P-2*: determine the baseline rate The first graduation from this program will occur in DY4 (1 fellow)

DY4
IT- 14.7 Zero percent of graduates will meet metric
DY5
IT- 14.7: 50% percent of graduates will meet metric
Rationale: P-1 and P-2 reflects the steps necessary to develop the resources to report on an improvement target and establish the baseline rate. Our first graduate from this fellowship will be in DY4, and at end of DY5 there will be two graduates.

Outcome Measure Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional

initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.10	*3.IT-14.7*	IT- 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.7		
Starting Point/Baseline:	*TO be determined inDY3*		
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: Implementation plan Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $21,119	**Process Milestone 2** [*P-2*]: Establish baseline rate: Metric [P-2.1]: Determine baseline rate. Goal: We will determine the baseline for the selected improvement target. Data Source: EMR, Scheduling system Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $48,959	**Outcome Improvement Target 1** TBD Improvement Target: [IT- 14.7]Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Goal: Zero percent of graduates will meet metric Data Source: systematic survey Outcome Improvement Target 1: Estimated Incentive Payment *(maximum amount):* $52,375	**Outcome Improvement Target 2** TBD Improvement Target: [IT- 14.7]Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Goal: 50% percent of graduates will meet metric Data Source: systematic survey Outcome Improvement Target 2: Estimated Incentive Payment *(maximum amount):* $60,000
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount: $48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount: $60,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $182,453			

Title of Outcome Improvement Target: . IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number: 084597603.3.11

Related Category 1 or 2 Project: 084597603.1.7

Outcome Measure Description:

. IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY2

- *P-1:* engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3

- *P-2*: determine the baseline rate The first graduation from this program will occur in DY4 (1 fellow)

DY4

IT- 14.8 Zero percent of graduates will meet metric

DY5

- IT- 14.8: 50% percent of graduates will meet metric

Rationale: P-1 and P-2 reflects the steps necessary to develop the resources to report on an improvement target and establish the baseline rate. Our first graduate from this fellowship will be in DY4, and at end of DY5 there will be two graduates.

Outcome Measure Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.11	*3.IT- 14.8*	IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.7		
Starting Point/Baseline:	*TO be determined inDY3*		
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: Implementation plan Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $21,119	**Process Milestone 2** [*P-2*]: Establish baseline rate: Metric [P-2.1]: Determine baseline rate. Goal: We will determine the baseline for the selected improvement target. Data Source: EMR, Scheduling system Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $48,959	**Outcome Improvement Target 1** TBD Improvement Target: IT – 14.8] Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey Goal: Zero percent of graduates will meet metric Data Source: systematic survey Outcome Improvement Target 1: Estimated Incentive Payment *(maximum amount):* $52,375	**Outcome Improvement Target 2** TBD Improvement Target: IT – 14.8] Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey Goal: 50% percent of graduates will meet metric Data Source: systematic survey Outcome Improvement Target 2: Estimated Incentive Payment *(maximum amount):* $60,000
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount: $48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount: $60,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $182,453			

Title of Outcome Measure (Improvement Target): IT-1.12 Diabetes care: Retinal eye exam

Unique RHP outcome identification number: 084597603.3.12

Related Category 1 or 2 Project: 084597603.2.1

Performing Provider / TBI TEXAS TECH HS CTR FAMILY MED / 084597603

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 for compliance with IT-1.12. The target population will be all patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes.

DY4

- IT-1.12 The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the baseline established in DY3

DY5

- IT-1.12 The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the rate in DY4

Our population suffers from a high prevalence of, and disproportionate impact from diabetes. Furthermore, our patient population is heavily represented by the uninsured or under-insured. Given the profound shortage of primary care providers in the Region, access to comprehensive primary care of diabetes in our population is extremely challenging. As such, we have made the decision to focus improvement targets in this project on markers of diabetes care.

Eye care in particular is a challenge. The Region as a whole suffers from a shortage of ocular care. The performing provider's resources in this area are limited currently to a single therapeutic optometrist. Even in funded patients, compliance with this standard is challenging: less than 50% of patients in our Region from one of our major managed Medicare plans are compliant with this metric.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as

Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.12	3.IT-1.12	Diabetes care: Retinal eye exam	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.2.1		
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-1] *engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.* *Data Source: meeting notes, attendance records, project timelines.* *Process Milestone 1 Estimated Incentive Payment (maximum amount): $21,119*	**Process Milestone 2** [*P-2*]: Establish baseline rate Metric [P-2.1] Establish baseline rate for compliance with IT-1.12 in the Kenworthy Family Medicine Clinic. Data Source: EMR, scheduling system Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $48,959	**Outcome Improvement Target1** [IT-1.12]: Diabetes care: Retinal eye exam- NQF 0055 (Non- standalone measure) Goal: The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Clinic will increase by 10% from the baseline established in DY3 Data Source: EMR, scheduling system Outcome Improvement Target 1 Estimated Incentive Payment: $52,375	**Outcome Improvement Target1** [IT-1.12]: Diabetes care: Retinal eye exam- NQF 0055 (Non- standalone measure) Goal: The % of patients who meet the requirements of IT-1.12in the Kenworthy Family Medicine Clinic will increase by 10% from the rate in DY4 Data Source: EMR, scheduling system Outcome Improvement Target 1 Estimated Incentive Payment: $167,716
Year 2 Estimated Outcome Amount: $21,119	Year 3 Estimated Outcome Amount $ 48,959	Year 4 Estimated Outcome Amount: $52,375	Year 5 Estimated Outcome Amount: $167,716
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $*290,169*			

Title of Outcome Measure (Improvement Target): IT-1.13 Diabetes care Foot exam

Unique RHP outcome identification number: 084597603.3.13

Related Category 1 or 2 Project: 084597603.2.1

Performing Provider / TBI TEXAS TECH HS CTR FAMILY MED / 084597603

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 for compliance with IT-1.13. The target population will be all patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes.

DY4

- IT-1.13 The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the baseline established in DY3

DY5

- IT-1.13 The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the rate in DY4.

Our population suffers from a high prevalence of, and disproportionate impact from diabetes. Furthermore, our patient population is heavily represented by the uninsured or under-insured. Given the profound shortage of primary care providers in the Region, access to comprehensive primary care of diabetes in our population is extremely challenging. As such, we have made the decision to focus improvement targets in this project on markers of diabetes care. Regular foot exams are an essential component of comprehensive diabetes care.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.13	3.IT-1.13	Diabetes care Foot exam	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects::	084597603.2.1		
Starting Point/Baseline:	*To be collected 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] engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: meeting notes, attendance records, project timelines. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $21,119	**Process Milestone 2** [*P-2*]: Establish baseline rate Metric [P-2.1] Establish baseline rate for compliance with IT-1.13 in the Kenworthy Family Medicine Clinic. Data Source: EMR, scheduling software Process Milestone 2 Estimated Incentive Payment *(maximum amount:* $48,959	**Outcome Improvement Target1** [IT-1.13]: Diabetes care Foot exam-NQF 0056 (Non- standalone measure***)*** Goal: The % of patients who meet the requirements of IT-1.13 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the baseline established inDY3 Data Source: EMR, scheduling software **Outcome Improvement Target** 1 Estimated Incentive Payment: $52,374	**Outcome Improvement Target1** [IT-1.13]: Diabetes care Foot exam-NQF 0056 (Non- standalone measure***).*** Goal: The % of patients who meet the requirements of IT-1.13 in the Kenworthy Family Medicine Clinic will increase by 10% from the rate in DY4 Data Source: EMR, scheduling software **Outcome Improvement Target** 1 Estimated Incentive Payment: $167,716
Year 2 Estimated Outcome Amount: *:* $21,119	Year 3 Estimated Outcome Amount: $48,959	Year 4 Estimated Outcome Amount $52,374	Year 5 Estimated Outcome Amount: $167,716
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $290,168			

Title of Outcome Measure (Improvement Target): IT-1.14 Diabetes care: *Microalbumin/Nephropathy*

Unique RHP outcome identification number: 084597603.3.14

Related Category 1 or 2 Project: 084597603.2.1

Performing Provider / TBI TEXAS TECH HS CTR FAMILY MED / 084597603

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 for compliance with IT-1.13. The target population will be all patients assigned to the PCMH at Kenworthy with a diagnosis of diabetes.

DY4

- IT-1.13 The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the baseline established in DY3

DY5

- IT-1.13 The % of patients who meet the requirements of IT-1.12 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the rate established in DY4

Our population suffers from a high prevalence of, and disproportionate impact from diabetes. Furthermore, our patient population is heavily represented by the uninsured or under-insured. Given the profound shortage of primary care providers in the Region, access to comprehensive primary care of diabetes in our population is extremely challenging. As such, we have made the decision to focus improvement targets in this project on markers of diabetes care. The detection and recognition of kidney disease early in it's course is an essential component of comprehensive diabetes care.

Valuation: The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.14	3.IT-1.14	**Diabetes care:** ***Microalbumin/Nephropathy***	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.2.1		
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-1]: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: meeting notes, attendance records, project timelines. Process Milestone 1 Estimated Incentive Payment *(maximum amount): $*21,119	**Process Milestone 2** [*P-2*]: Establish baseline rates. Metric [P-2.1]: Establish baseline rate for compliance with IT-1.14 in the Kenworthy Family Medicine Clinic. Data Source: EMR, scheduling software Process Milestone 2 Estimated Incentive Payment *(maximum amount:*$ 48,959	**Outcome Improvement Target1** [IT-1.14]: Diabetes care: Microalbumin/Nephropathy- NQF 0062 (Non- standalone measure) Goal: The % of patients who meet the requirements of IT-1.14 in the Kenworthy Family Medicine Primary Care Medical Home increase by 10% from the baseline established in DY3 Data Source: EMR, scheduling software **Outcome Improvement Target** 1 Estimated Incentive Payment: $52,374	**Outcome Improvement Target 2** [IT-1.14]:]: Diabetes care: Microalbumin/Nephropathy- NQF 0062 (Non- standalone measure) Goal: The % of patients who meet the requirements of IT-1.14 in the Kenworthy Family Medicine Primary Care Medical Home will increase by 10% from the rate established in DY DY4. Data Source: EMR, scheduling software **Outcome Improvement Target** 1 Estimated Incentive Payment: $167,716
Year 2 Estimated Outcome Amount: *$*21,119	Year 3 Estimated Outcome Amount: $ 48,959	Year 4 Estimated Outcome Amount $52,374	Year 5 Estimated Outcome Amount: $167,716
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $290,168			

Title of Outcome Measure (Improvement Target): IT-14.6: Primary Care Residency Training Program

RHP Performing Provider / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number(s): 084597603.3.15 Pass 2

Outcome Measure Description:
IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

- Rate 1: Percent of child psychiatry program trainees who have spent at least 5 years living in the El Paso County HPSA

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 for rates 1 and 2

Outcome Improvement Targets for each year:

- DY4:
  - IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)—10% improvement over DY3 baseline
- DY5:
  - IT- 14.6 (non-standalone measure): Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA) —20% improvement over DY3 baseline

Rationale:
The Texas Tech Category 1 proposal to expand a Child Psychiatry Fellowship Program is designed to leverage an existing residency training program in order to train more child psychiatrists. Given the historical precedent that most of our graduating medical residents practice within 75 miles of their training site, this proposal is an excellent opportunity to recruit more physicians to underserved areas of the state, including El Paso. Texas Tech believes that the successful implementation of this Category 1 project will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 project will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:

The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.15 Pass 2	*IT-14.6,*	*Expansion of Child Psychiatry Fellowship*	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.8 Pass 2		
Starting Point/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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $3,438	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $7,972	**Outcome Improvement Target 1** [IT-14.6]: Percent of trainees who have spent at least 5 years living in an HPSA or MUA. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 1 Estimated Incentive Payment*:* $8,527	**Outcome Improvement Target 2** [IT-14.6]: Percent of trainees who have spent at least 5 years living in an HPSA or MUA. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 2 Estimated Incentive Payment*:* $18,537 Outcome Improvement Target 2 Estimated Incentive Payment*:* $18,537
Year 2 Estimated Outcome Amount: $3,438	Year 3 Estimated Outcome Amount: $7,972	Year 4 Estimated Outcome Amount: $8,527	Year 5 Estimated Outcome Amount: $18,537
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $38,474			

Title of Outcome Measure (Improvement Target): IT-14.7: Primary Care Residency Training Program

Performing Provider Name / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number(s): 084597603.3.16 Pass 2

Outcome Measure Description:
IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

- Rate 1: Percent of child psychiatry program trainees who report that they plan to practice in HPSAs or MUAs

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 for rates 1 and 2

Outcome Improvement Targets for each year:

- DY4:
  - IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey—10% improvement over DY3 baseline
- DY5:
  - IT-14.7 (non-standalone measure): Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey—20% improvement over DY3 baseline

Rationale:
The Texas Tech Category 1 proposal to expand a Child Psychiatry Fellowship Program is designed to leverage an existing residency training program in order to train more child psychiatrists. Given the historical precedent that most of our graduating medical residents practice within 75 miles of their training site, this proposal is an excellent opportunity to recruit more physicians to underserved areas of the state, including El Paso. Texas Tech believes that the successful implementation of this Category 1 project will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 project will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:

The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.16 Pass 2	*IT-14.7,*	*Expansion of Child Psychiatry Fellowship*	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.8 Pass 2		
Starting Point/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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $3,439	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $7,972	**Outcome Improvement Target 2** [IT-14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 2 Estimated Incentive Payment*:* $8,527	**Outcome Improvement Target 5** [IT-14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 5 Estimated Incentive Payment*:* $18,537
Year 2 Estimated Outcome Amount: $3,439	Year 3 Estimated Outcome Amount: $7,972	Year 4 Estimated Outcome Amount: $8,527	Year 5 Estimated Outcome Amount: $18,537
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $38,475			

Title of Outcome Measure (Improvement Target): IT-14.8: Primary Care Residency Training Program

Performing Provider Name / TPI: TEXAS TECH HS CTR FAMILY MED / 084597603

Unique RHP outcome identification number(s): 084597603.3.17 Pass 2

Outcome Measure Description:
IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

- Rate 1: Percent of child psychiatry program trainees who report that they plan to serve Medicaid populations

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 for rates 1 and 2

Outcome Improvement Targets for each year:

- DY4:
  - IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey—10% improvement over DY3 baseline
- DY5:
  - IT-14.8 (non-standalone measure): Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey—20% improvement over DY3 baseline

Rationale:
The Texas Tech Category 1 proposal to expand a Child Psychiatry Fellowship Program is designed to leverage an existing residency training program in order to train more child psychiatrists. Given the historical precedent that most of our graduating medical residents practice within 75 miles of their training site, this proposal is an excellent opportunity to recruit more physicians to underserved areas of the state, including El Paso. Texas Tech believes that the successful implementation of this Category 1 project will result in more of the trainees in these programs choosing to practice in underserved areas such as El Paso; these trainees will spend more time living in El Paso, will be more likely to plan to practice in underserved areas, and will be more likely to plan to serve Medicaid and uninsured populations. Therefore, the successful implementation of the associated Category 1 project will result in a measurable increase in each of the three Category 3 outcome measures identified in this Category 3 project.

Outcome Measure Valuation:

The Performing Provider considered a series of factors in establishing a valuation for each project. These included the amount of human resources required to meet the milestones of the project, through new hires as well as the assignment of existing support personnel such as Information Technology, EMR and administrative support. We considered what non personnel resources would be required, such as equipment specialized for a certain specialty, and what, if any, additional space would be required to house the initiative. We considered timing issues related to when we had to add resources compared to when a corresponding milestone could be achieved. We also considered the amounts of potential professional fee revenues the project may generate, and offset these against resource demands.

We made a risk assessment for each project, considering the complexity, the scope, the extent to which any single point failure in the milestones would jeopardize downstream success, the degree of inter-dependence on other projects within the waiver program as well as institutional initiatives outside the waiver, and the amount of time required to manage the project. We made an assessment of potential general community benefit.

Finally, we considered organizational priorities, and to what extent the Performing Provider was able to justify partial support of these efforts as meeting existing institutional requirements or objectives.

084597603.3.17 Pass 2	*IT-14.8*	*Expansion of Child Psychiatry Fellowship*	
TEXAS TECH HS CTR FAMILY MED			084597603
Related Category 1 or 2 Projects:	084597603.1.8 Pass 2		
Starting Point/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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $3,439	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Systematic survey. Process Milestone 2 Estimated Incentive Payment: $7,972	**Outcome Improvement Target 3** [IT-14.6]: Percent of trainees who report that they plan to serve Medicaid populations. Improvement Target: 10% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 3 Estimated Incentive Payment*:* $8,527	**Outcome Improvement Target 6** [IT-14.6]: Percent of trainees who report that they plan to serve Medicaid populations. Improvement Target: 20% improvement over DY3. Data Source: Systematic survey. Outcome Improvement Target 6 Estimated Incentive Payment*:* $18,537
Year 2 Estimated Outcome Amount: $3,439	Year 3 Estimated Outcome Amount: $7,972	Year 4 Estimated Outcome Amount: $8,527	Year 5 Estimated Outcome Amount: $18,537
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $38,475			

Performing Provider Name/TPI: **Emergence Health Network/127376505**

Title of Outcome Measure (Improvement Target): **IT-9.2 ED appropriate utilization**
Unique RHP outcome identification number(s): **127376505 3.1**

Outcome Measure Description:
IT-9.2 ED appropriate utilization

- Reduce Emergency Department visits for target conditions
  - Behavioral Health/Substance Abuse

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

Outcome Improvement Targets for each year:

- DY3:
  - IT-9.2 ED appropriate utilization
    - Reduce Emergency Department visits for target conditions
      - Behavioral Health/Substance Abuse
- DY4:
  - IT-9.2 ED appropriate utilization
    - Reduce Emergency Department visits for target conditions
      - Behavioral Health/Substance Abuse
- DY5
  - IT-9.2 ED appropriate utilization
    - Reduce Emergency Department visits for target conditions
      - Behavioral Health/Substance Abuse

Rationale:
Process milestones – P-1 and P-2 were chosen to measure and monitor emergency department utilization. In order to report accurate data and establish baselines, P-2 must be approached in DY2.

The improvement target was chosen based on the timeframe allowed to put in place the proper resources and processes needed to collect data. The outcome measure being addressed is affected by community education and willingness to use the service array.

Outcome Measure Valuation: EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals with a behavioral health diagnosis. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments. It has been demonstrated that the utilization of psychiatric emergency services is cost effective and is a best practice in addressing behavioral health needs of individuals presenting in crisis. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

127376505.3.1	*9.IT.9.2*	*OD-9 Right Care, Right Setting* *IT-9.2 ED appropriate utilization*	
Emergence Health Network			*127376505*
Related Category 1 or 2 Projects:	*127376505.1.1*		
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: Plans and agendas Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** P-2: Establish baseline rates Data Source: Baseline data Process Milestone 2 Estimated Incentive Payment: $0	**Outcome Improvement Target 1** IT-9.2: ED appropriate utilization Improvement Target: TBD Data Source: ED Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $459,596	**Outcome Improvement Target 2** IT-9.2: ED appropriate utilization Improvement Target: TBD Data Source: ED Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $555,745	**Outcome Improvement Target 3** IT-9.2: ED appropriate utilization Improvement Target: TBD Data Source: ED Data Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,451,366
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $459,596	Year 4 Estimated Outcome Amount: $555,745	Year 5 Estimated Outcome Amount: $1,451,366
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,466,707			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) Are getting timely care, appointments, and information.
Unique RHP outcome identification number(s): 127376505 3.2

Outcome Measure Description:
IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) Are getting timely care, appointments, and information.

Process Milestones:

- DY2:
  - P-1 - Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Outcome Improvement Targets for each year:

- DY3:
  - IT 6.1 Percent improvement over baseline of patient satisfaction scores
- 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:

EHN chose process milestone P-1 to identify needed resources and to implement interventions to increase behavioral health providers. EHN chose OD-6/IT 6.1 as an outcome measure as customer satisfaction is an indicator of enhanced access to behavioral health including choice in providers.

Outcome Measure Valuation:
EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals with a behavioral health diagnosis. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments, law enforcement, and other systems of care. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

127376505.3.2	*9.IT.6.1*	*OD-6 Patient Satisfaction* *IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information*	
Emergence Health Network			*127376505*
Related Category 1 or 2 Projects:	*127376505.1.2*		
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: Plans and agendas Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Outcome Improvement Target 1** IT-6.1: Percent improvement over baseline of patient satisfaction scores Improvement Target: TBD Data Source: Survey Results Outcome Improvement Target 1 Estimated Incentive Payment*:* $85,353	**Outcome Improvement Target 2** IT-6.1: Percent improvement over baseline of patient satisfaction scores Improvement Target: TBD Data Source: Survey Results Outcome Improvement Target 2 Estimated Incentive Payment*:* $87,913	**Outcome Improvement Target 3** IT-6.1: Percent improvement over baseline of patient satisfaction scores Improvement Target: TBD Data Source: Survey Results Outcome Improvement Target 3 Estimated Incentive Payment*:* $203,739
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $85,353	Year 4 Estimated Outcome Amount: $87,913	Year 5 Estimated Outcome Amount: $203,739
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $377,005			

Performing Provider Name/TPI: Emergence Health Network/127376505

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life
Unique RHP Outcome identification number(s): 127376505 3.3
Outcome Measure Description:
OD-10 Quality of Life/Functional Status
IT- 10.1 Quality of Life

Process Milestones:

- DY2:
  - P-1 – Project Planning
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-10.1 Quality of Life
- DY5:
  - IT-10.1 Quality of Life

Rationale:
EHN chose OD-10/IT-10.1 as an outcome measure to demonstrate improvement in symptoms and functioning. START outcomes have shown increased benefits to clients overtime including improvement in the Aberrant Behavior Checklist (validated functioning assessment tool) scores and Family Experiences Interview Schedule (FEIS) developed by Tessler and Gamache (1995) which measures significant aspects of mental health service effectiveness from a family member perspective. START clients tend to stay out of the hospital and not seek emergency healthcare services when they are in the program. Quality of life is evidenced by the START Program's national statistic which includes its current retention rate for home placements of 95%, two-day reduction in average length of stay per hospitalization, and improvement in mental health outcome measures and comparisons.

Outcome Measure Valuation:
EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals diagnosed with an intellectual/developmental disability. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments and other systems of care. It has been demonstrated that the utilization of an IDD crisis stabilization units is cost effective and is a best practice in addressing the needs of individuals presenting in crisis. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

127376505.3.3	*10.IT.10.1*	*OD-10 Quality of Life/Functional Status* *IT-10.1 Quality of Life*	
Emergence Health Network			*127376505*
Related Category 1 or 2 Projects:	*127376505 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 – engaging stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Attendance list. Process Milestone 1 Estimated Incentive Payment: $0	***Process Milestone 1*** *P-2:* Establish baseline rates. Data Source: high risk clients defined by medical necessity. Process Milestone 2 Estimated Incentive Payment*:* $107,695	**Outcome Improvement Target 2** IT-10.1: Quality of life Improvement Target: TBD Data Source: Validated assessment tool: Aberrant Behavior Checklist (validated functioning assessment tool) scores and Family Experiences Interview Schedule (FEIS) Outcome Improvement Target 2 Estimated Incentive Payment*:* $106,514	**Outcome Improvement Target 3** IT-10.1: Quality of life Improvement Target: TBD Data Source: Validated assessment tool: Aberrant Behavior Checklist (validated functioning assessment tool) scores and Family Experiences Interview Schedule (FEIS) Outcome Improvement Target 3 Estimated Incentive Payment*:* $253,158
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $107,695	Year 4 Estimated Outcome Amount: $106,514	Year 5 Estimated Outcome Amount: $253,158
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $467,367			

Performing Provider Name/TPI: **Emergence Health Network/127376505**

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization
Unique RHP outcome identification number(s): **127376505** 3.4

Outcome Measure Description:
IT-9.2 ED appropriate utilization

- Reduce Emergency Department visits for target conditions
  - Behavioral Health/Substance Abuse

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

Outcome Improvement Targets for each year:

- DY3:
  - IT-9.2 ED appropriate utilization
    - Reduce Emergency Department visits for target conditions
      - Behavioral Health/Substance Abuse
- DY4:
  - IT-9.2 ED appropriate utilization
    - Reduce Emergency Department visits for target conditions
      - Behavioral Health/Substance Abuse
- DY5
  - IT-9.2 ED appropriate utilization
    - Reduce Emergency Department visits for target conditions
      - Behavioral Health/Substance Abuse

Rationale: Process milestones – P-1 and P-2 were chosen to measure and monitor emergency department utilization. In order to report accurate data and establish baselines, P-2 must be approached in DY2.

The improvement target was chosen based on the timeframe allowed to put in place the proper resources and processes needed to collect data. The outcome measure being addressed is affected by community education and willingness to use the service array.

Outcome Measure Valuation: EHN determined the value of this project by considering the overall benefit to the community and individuals served. Implementation of this project ensures appropriate treatment in the "right care and right setting" for individuals with a behavioral health diagnosis. In addition, community stakeholders benefit from reduced costs resulting from inappropriate utilization of local emergency departments. It has been demonstrated that the utilization of psychiatric emergency services is cost effective and is a best practice in addressing behavioral health needs of individuals presenting in crisis. The purpose of this project is to ensure the objective of the waiver is met by improving patient outcomes, decreasing unnecessary costs, and ameliorating the behavioral healthcare delivery system.

127376505.3.4	*9.IT.9.2*	*OD-9 Right Care, Right Setting* *IT-9.2 ED appropriate utilization*	
Emergence Health Network			*127376505*
Related Category 1 or 2 Projects:	*127376505.2.1*		
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: Plans and agendas Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** P-2: Establish baseline rates Data Source: Baseline data Process Milestone 2 Estimated Incentive Payment: $0	**Outcome Improvement Target 1** IT-9.2: ED appropriate utilization Improvement Target: TBD Data Source: ED Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $515,611	**Outcome Improvement Target 2** IT-9.2: ED appropriate utilization Improvement Target: TBD Data Source: ED Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $499,612	**Outcome Improvement Target 3** IT-9.2: ED appropriate utilization Improvement Target: TBD Data Source: ED Data Outcome Improvement Target 3 Estimated Incentive Payment*:* $808,651
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $515,611	Year 4 Estimated Outcome Amount: $499,612	Year 5 Estimated Outcome Amount: $808,651
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,823,874			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life
Unique RHP Outcome identification number(s): 127376505 3.5 Pass 2

Outcome Measure Description:
OD-10 Quality of Life/Functional Status
IT- 10.1 Quality of Life

Process Milestones:

- DY2:
  - P-2 - Establish baseline rates

Outcome Improvement Targets for each year:

- DY3:
  - IT-10.1 Quality of Life
- DY4:
  - IT-10.1 Quality of Life
- DY5:
  - IT-10.1 Quality of Life

Rationale:
EHN chose process milestone P-2 to establish a baseline to demonstrate improved quality of life. EHN chose OD-10/IT-10.1 as an outcome measure to improve symptoms and functioning. The anticipated outcome for the selected project is that there will be demonstrated improvement in individuals clinical outcomes.

Outcome Measure Valuation:

Valuation of this project was based on average cost and length of stay related to individuals that require inpatient hospitalization, individuals served by local emergency departments, and individuals incarcerated.

127376505.3.5 Pass 2	*IT-10.1*	*OD-10 Quality of Life/Functional Status* *IT-10.1 Quality of Life*	
Emergence Health Network			*127376505*
Related Category 1 or 2 Projects:	*127376505 2.2 Pass 2*		
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-2:* Establish baseline rates Data Source: Baseline data Process Milestone 1 Estimated Incentive Payment: $20,513	**Outcome Improvement Target 1** IT-10.1: Quality of life Improvement Target: TBD Data Source: Validated assessment tool Outcome Improvement Target 1 Estimated Incentive Payment*:* $23,778	**Outcome Improvement Target 2** IT-10.1: Quality of life Improvement Target: TBD Data Source: Validated assessment tool Outcome Improvement Target 2 Estimated Incentive Payment*:* $25,435	**Outcome Improvement Target 3** IT-10.1: Quality of life Improvement Target: TBD Data Source: Validated assessment tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $55,294
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $20,513	Year 3 Estimated Outcome Amount: $23,778	Year 4 Estimated Outcome Amount: $25,435	Year 5 Estimated Outcome Amount: $55,294
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $125,019			

City of El Paso Department of Public Health
DSRIP Project: Border Public Health Interest Group
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target): IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity
Unique RHP outcome identification number: 065086301.3.1

Outcome Measure Description:

IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity

Goal: Provision of three clinical preventive services (annual flu vaccine, Tdap booster and/or lipid screening) to 1,250 minority adults

Data Source: Performing provider

The City of El Paso Department of Public Health is proposing a four year developmental effort to operationalize a Border Public Health Interest Group (BPHIG) around the theme of collection and analysis of REAL data. Currently, the three academic institutions in the El Paso area (University of Texas El Paso, University of Texas Houston School of Public Health, and Texas Tech University) are engaged in population-based research activity. This regional research involves the collection and analysis of race, ethnicity, and language data with the intent to identify and ameliorate health disparities. Though the three research institutions have embraced collection of REAL data, there has been no assessment of the use of REAL data systems among El Paso area institutional healthcare providers, community health centers or private physicians The Border Public Health Interest Group will conduct the community assessment on the use of REAL data systems; invite early adopters of REAL to be members of the Interest Group; and identify opportunities for development/implementation of standardized REAL data collection. Through community deployment of new epidemiology staff supported through the DSRIP project, the health department will play a pivotal (and neutral) role in advancing community discussion of the need for REAL data collection and its value in identifying disparities related to race, ethnicity, and language. In addition to encouraging community adoption of REAL data collection systems, BPHIG will identify one or more collaborative research opportunities including improvement in select preventive health services compliance rates among minority adults where REAL data collection will be foundational to the research. Results of the research will inform the community on the value REAL data collection for problem description and aid the development of appropriate public policies and targeted interventions.

Process Milestones:

- DY 2:
  - P-1-Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
  - P-3-Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:

IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity: Identify/provide annual flu vaccine, Tdap booster and/or lipid screening to 500 minority adults

- DY5:

  IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity: Identify/provide annual flu vaccine, Tdap booster and/or lipid screening to 750 minority adults

Rationale:

Process Milestones P-1 and P-3 were chosen due to lack of an inventory of current population-based research activity being conducted by the three local universities. Further, it is unknown to what extent data collection underway is consistent with expectations for uniformity of REAL data. Assessment of scope of current activity and application of REAL data collection methodology will occur over the first two years of the project. Outcome of the assessment will drive the Outcome Improvement Target (s) for years DY4 and DY5.

The current demographic mix of El Paso is predictive for the nation (predominantly Hispanic with diverse socioeconomic status). As such, population-based research on prevalence and incidence of communicable and chronic diseases is especially relevant to healthcare providers and policy makers. Population-based research in the El Paso community will help describe/refine who's at risk for select diseases by race, ethnicity, language, physiologic, behavioral, socioeconomic factors. Further, specific interventions (health and other) can be studied to identify best practices for health protection and disease prevention/management/control in a predominantly Hispanic population**.**

Publicly funded research projects now require evidence of collaboration. Historically, the three academic institutions in the area pursued research tracts in isolation. The expectation for collaboration is a paradigm shift. However, this shift can be facilitated by the health department as a neutral convener.

Population-based research in the El Paso community will help describe/refine who's at risk for select diseases by race, ethnicity, language, physiologic, behavioral, socioeconomic and other factors AND who may be protected by one or more of the above factors. Further, specific interventions (health and other) can be studied to identify best practices for disease prevention/management/control in a predominantly Hispanic population. Work of the Border Public Health Interest Group will inform/influence health planners, clinicians, and policy makers and, therefore, is translational to all DSRIP categories.

Outcome Measure Valuation:

The proposed value (community benefit) of the Border Public Health Interest Group (BPHIG) is $5,933,708 over the DSRIP funding period (DY 2-5). Of this amount $1,623,917 has been allocated for the value of Category 3 Quality Improvements. The valuation takes into account direct personnel and operational expenses to support Category 3 activities; costs associated with technical consultation and, as needed, REAL data software design/purchase; and the community

benefit value of conducting REAL data research on area health problems with the intent of informing the community of findings and building community constituencies for policy change and program development.

065086301.3.1	*3.IT-11.3*	*Improve utilization rates of clinical preventive services in target population with identified disparity*	
Performing Provider Name: City of El Paso Department of Public Health			*TPI-065086301*
Related Category 1 or 2 Projects:	*065086301.1.1*		
Starting Point/Baseline:	*New Initiative: 0*		
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)**
Category 3 **Process Milestone** P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Process Milestone Metric** Goal: Develop fully functional Border Public Health Interest Group (BPHIG) with full participation of three local universities; recruit and select two epidemiologists and one support staff to assist BPHIG in business planning and research design; develop and approve three year strategic plan for: • inventorying existing research projects; • determining extent of compliance with REAL data collection methodology; • applying REAL data methods and expectations to data collection on existing research projects; • expanding participation on	**Category 3** **Process Milestone** P-3 Develop and test data systems **Process Milestone Metric** Goal: Research/inventory existing REAL data collection systems being used by hospitals, community health centers, private providers within and outside El Paso. Identify and involve early adopters. If possible, modify existing REAL data collection systems to reflect local needs. Identify collaborative research opportunity for piloting of REAL data system. Data Source: Performing Provider Estimated Incentive Payment:	**Category 3** **Outcome Improvement Target** IT 11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity Goal: Through REAL data collection and analysis identify 500 minority adults in need of flu vaccine, Tdap booster, and/or lipid screening; provision of necessary preventive services to target population Data Source: Performing Provider Estimated Incentive Payment*:* $500,000	**Category 3** **Outcome Improvement Target** IT 11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity Goal: Through REAL data collection and analysis identify 750 additional minority adults in need of flu vaccine, Tdap booster, and/or lipid screening; provision of necessary preventive services to target population Data Source: Performing Provider Estimated Incentive Payment*:* $673,917

065086301.3.1	*3.IT-11.3*	*Improve utilization rates of clinical preventive services in target population with identified disparity*	
Performing Provider Name: City of El Paso Department of Public Health			*TPI-065086301*
Related Category 1 or 2 Projects:	*065086301.1.1*		
Starting Point/Baseline:	*New Initiative: 0*		
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)**
BPHIG; • identification of collaborative research opportunities Data Source: Performing Provider Estimated Incentive Payment *:* $50,000	$400,000		
Year 2 Estimated Outcome Amount: $50,000	Year 3 Estimated Outcome Amount: $400,000	Year 4 Estimated Outcome Amount: $500,000	Year 5 Estimated Outcome Amount: $673,917
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,623,917			

City of El Paso Department of Public Health
DSRIP Project: El Paso Community Health Atlas
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target): IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity

Unique RHP outcome identification number: 065086301.3.2

Outcome Measure Description:
IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity

Goal: Provision of three clinical preventive services (annual flu vaccine, Tdap booster and/or lipid screening) to 1,250 minority adults

Data Source: Performing provider

The City of El Paso Department of Public Health is proposing a four year developmental effort to establish/use an El Paso Community Health Atlas for describing health status at zip code level and informing researchers, policy makers and service providers. The Atlas data repository initiative will be integrated with the Border Public Health Interest Group (BPHIG) project (065086301.1.1) to demonstrate the value of collection and analysis of REAL data to improve compliance rates for clinical preventive services among minority adults. Over the course of DY4 and DY5, 1,250 minority adults in need of one or more clinical preventive services (flu vaccine, Tdap booster, lipid screening) will be identified from the Atlas data repository and services provided.

The backbone of systemic improvement (cost and quality) in identifying clients in need of clinical preventive services and assuring delivery of needed service is the Community Health Atlas. To achieve more accurate feedback on whether investments into public health are effective, policy leaders and others need reporting systems that tell them: 1) where funds and efforts should be should focused in order to achieve the most leveraged return; and 2) whether or not progress is being achieved. Like many communities, El Paso lacks a user-friendly data repository where this information can be compiled. This project, the proposed El Paso Community Health Atlas, will address that need and produce a comprehensive database that stores present and collected biomarker information linked to zip codes, to establish a baseline against which future data can be compared.

Through this project, El Paso's policy and practice leaders will be able to make decisions that impact public health using real-time data. Resources can be utilized more wisely once the baseline of biomarker data is established for every zip code. Over time, the true value of this critical investment in public health information infrastructure will be realized by enabling public health leaders and community stakeholders to track specific outcomes in cost, quality and effectiveness against the starting baseline.

Process Milestones:

- DY 2:

    - P-1 -Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
    - P-3 –Develop and test data systems

Outcome Improvement Targets for each year:

- DY 4:
- IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity: Identify/provide annual flu vaccine, Tdap booster and/or lipid screening to 500 minority adultsDY5:

  IT 11.3 Improve utilization rates of clinical preventive services in target population with identified disparity: Identify/provide annual flu vaccine, Tdap booster and/or lipid screening to 750 minority adults

Rationale:

Process Milestones P-1 and P-3 were chosen because of the extensive developmental work that will need to be done to prepare the El Paso Community Health Atlas. This preparatory work includes inventorying existing health databases; assessing the capacity to integrate data systems or, otherwise, assure access to the full depth and breadth of health data; identifying gaps in health information, especially as they relate to REAL data collection; and developing a plan for field collection of de-identified biomarker data. The outcome of the preparatory work will drive the Outcome Improvement Target for years DY4 and DY5. These desired outcomes will include development/use of display/reporting models which will improve understanding of area health conditions and inform decision makers on efficient deployment of resources relative to needs at a zip code level. Further, availability of REAL data through the Atlas will facilitate identification of 1,250 minority adults in need of clinical preventive services. These adults will be assessed for deficiency in one or more clinical preventive services (flu vaccine, Tdap booster, lipid screening). Targeted interventions will be developed to efficiently provide clinical services to the affected population.

A critical component of the Health Atlas initiative will be the collection, analysis, and reporting of biomarker data. Bio-markers which predict prodromal signs enable earlier diagnosis and/or allow for the outcome of interest to be determined at an earlier stage of disease. Biomarkers used for screening or diagnosis often represent surrogate manifestations of disease and can be used to : a) identify individuals destined to become affected or are in the preclinical states of illness; b) reduce disease heterogeneity; and c) reflection of the history of disease encompassing the phases of induction, latency, and detection.

The Community Health Atlas project will employ mobile measurement in RHP Region 15 to map precursors of disease/conditions and assess trends in health status among the population.

Biomarkers are used to monitor and predict the health of a population. Alone or in combination, biomarkers can provide an early warning system of risk for future adverse health outcomes. Many biomarkers are easy to measure. Cardiovascular indicators include blood pressure, heart rate, and pulse. Cholesterol and triglycerides provide information on metabolic processes and are used frequently to evaluate risk of coronary artery disease. Body measurements such as

height, weight, blood mass index (BMI) and waist to hip ratio serve as indicators of obesity, chronic metabolic disorders and fatty deposits. Blood glucose measurements including HbA1C provide information on risk of diabetes. Cytokines, C reactive protein provide indication of acute and chronic inflammatory disease. Single lead electrocardiogram provides indication of heart disease. Cystatin C and urinalysis (dipstick) provide indication of renal disease. PO2, respiratory frequency, and expiatory capacity are measures of cardiopulmonary function.

Biomarkers are much better predictors of disease and death than self-reported health status. An individual biomarker, once it exceeds a certain threshold, is an indicator of risk for future illness or death due to problems in a particular biological system. By adding risk indicators together, an index can be created that captures higher health risks.

Biomarkers are used to describe risk, exposures, intermediate effects of treatment, and biological mechanisms; as surrogate endpoints, biomarkers are used to predict health outcomes. "Biomarkers can provide information about risk and physiological parameters that is useful in a variety of contexts: (1) insight into the health and well-being of patients and consumers; (2) the status of patient and consumer response to an intervention; (3) a basis for interpreting research results and comparing across studies; (4) indications of health status and disease risk in population groups, and (5) important data for planning and evaluating health programs". (Medicine, 2010)

There are a variety of biomarkers which have great advantages for patients and consumers, physicians and other health professionals, scientists and researchers, industry, payers', regulators, and policy makers.

Of critical importance is to understand the difference between biomarkers, risk factors, and endpoints. Biomarkers are patient and consumer characteristics that are measured and evaluated. Risk factors are variables that predict outcomes and are composed of biomarkers and social and environmental factors.

The value of a risk factor depends on the degree to which it can predict an event. Lastly, there are endpoints which include biomarkers, alone or in combination with clinical events. Below are the biomarkers to be collected in this project.

Biomarkers	**Description**	**Associated health outcome**
Body Mass Index	Indicator of the balance between energy intake and energy expenditure	Cardiovascular disease, diabetes mellitus, stroke, mortality, osteoarthritis, and some forms of Cancer.
Fasting Glucose	Measures the amount of sugar in blood; indicator of diabetes	Diabetes, CHD, poor cognitive functioning, and mortality

Diastolic Blood Pressure	Index of cardiovascular activity; lowest pressure in an artery when the heart is resting	Cardiovascular disease, stroke, Coronary Heart Disease, mortality
Systolic Blood Pressure	Index of cardiovascular activity, maximum pressure in an artery when the heart is pumping blood throughout the body	Coronary Heart Disease, stroke, CVD, mortality
High Density Lipoprotein	Protective cholesterol	Lower risk of arthrosclerosis CVD
Low Density Lipoprotein	Transports cholesterol from the liver to be incorporated into cell membrane tissues	arthrosclerosis, stroke, peripheral vascular disease, CHD
Total Cholesterol	Aids in the synthesis of bile acids and steroid hormones	In middle ages individuals CHD and all-cause mortality are present. In older age, U shaped relation to death.
Triglycerides	Fat substance stored for energy use	Heart attack, CHD, coronary artery disease, pancreatitis
Resting pulse	Indicator of heart functioning and measure of overall fitness	CHD, mortality
Single lead EKG	Measurement of electrical impulses in the heart	Cardiovascular risk, stroke, mortality
Po2	Measure of blood oxygenation	Risk factor of cardiopulmonary and pulmonary disease
Forced expiratory pressure	Measure of lung capacity	Risk factor of pulmonary disease/conditions
Cystatin C	Measure of GFR	Decreased renal function, kidney failure
Urinalysis	Measure of metabolism, tubular and glomerular function	Alteration I renal function, and metabolic alteration, renal failure, infectious process

Outcome Measure Valuation:

The proposed value (community benefit) of the El Paso Community Health Atlas is $4,746,967 over the DSRIP funding period (DY 2-5). Of this amount $986,742 has been allocated for the value of Category 3 Quality Improvements. The valuation takes into account direct personnel and operational expenses to support Category 3 activities; costs associated with technical consultation and, as needed, REAL data software design/purchase; and the community benefit value of collecting and conducting research on REAL data to describe/refine area health problems with the intent of informing the community of findings; building community

constituencies for policy change and program development; and prescribing evidence-based interventions.

065086301.3.2	*3.IT 11.3*	*Improve utilization rates of clinical preventive services in target population with identified disparity*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects:	*065086301.1.2*		
Starting Point/Baseline:	*New Initiative: 0*		
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)**
Category 3 Process Milestone P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone Metric Goal: Inform stakeholders and broader community about the El Paso Community Health Atlas initiative; assess availability of health data from traditional and non-traditional sources; prepare related index; assess and address issues of inter-operability of databases; identify data gaps; prepare plan to collect de-identified biomarker data through deployment of a mobile health screening van to select areas of El Paso region. Data Source: Performing Provider Estimated Incentive Payment *:* $50,000	Category 3 Process Milestone P-3 Develop and test data systems Process Milestone Metric Goal: Conduct integrated analysis of existing REAL health data by zip code; supplement database, as needed, with biomarker data collected through mobile health screening van; identify trends and outlier results by zip code; begin mapping of results with data overlays; inform stakeholders and broader community of findings and opportunities to develop/implement effective interventions, i.e., describe and prescribe. Data Source: Performing Provider Estimated Incentive Payment: $289,780	Category 3 Outcome Improvement Target IT 11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity Goal: Through the Community Health Atlas, identify 500 minority adults in need of flu vaccine, Tdap booster, and/or lipid screening; provide clinical preventive services, as needed Data Source: Performing Provider Estimated Incentive Payment*:* $310,003	Category 3 Outcome Improvement Target IT 11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity Goal: Through the Community Health Atlas, identify 750 additional minority adults in need of flu vaccine, Tdap booster, and/or lipid screening; provide clinical preventive services, as needed Data Source: Performing Provider Estimated Incentive Payment*:* $336,959

065086301.3.2	*3.IT 11.3*	*Improve utilization rates of clinical preventive services in target population with identified disparity*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects:	*065086301.1.2*		
Starting Point/Baseline:	*New Initiative: 0*		
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 Outcome Amount: $50,000	Year 3 Estimated Outcome Amount: $289,780	Year 4 Estimated Outcome Amount: $310,003	Year 5 Estimated Outcome Amount: $336,959
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $986,742			

City of El Paso Department of Public Health
DSRIP Project: Expansion of Oral Health Services
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target): IT-7.2 Cavities: Percentage of Children with Untreated Dental Caries
Unique RHP outcome identification number: 065086301.3.3

Outcome Measure Description:

IT-7.2 Cavities: Percentage of Children with Untreated Dental Caries
Goal: 40% reduction in restorative work from DY3-5
Data Source: Review of patient records and activity data by performing provider

Outcome Measure Description:

The City of El Paso Department of Public Health is proposing a four year developmental effort to acquire, staff, and fully operationalize a mobile dental clinic to supplement current services of the health department's fixed-site Rawlings Dental Clinic. In the first two years of the project, the health department will use Process Milestones P-1: Project Planning and P-2: Establish Baseline Rates to guide and direct program activities. Developmental work will include purchase and outfitting of the mobile dental clinic; selection of professional and support staff; inventory of existing oral health resources in underserved areas and current utilization rates; identification of prospective deployment sites; cultivation of relationships with potential referral/deployment site sources; development of business plan including staffing, scheduling, accounts payable/receivable management, outreach/casefinding, and evaluation services. Outcome Improvement Target is to be determined from planning/preparation process. Estimate is that 1,000 additional children will be served by the mobile dental clinic. Further, it is estimated that one year after the initial cleaning and treatment, improvement in oral health practices will mitigate additional restorative work by 40%. By year two following initiation of dental service, there will be a 60% reduction in need for restorative care.

Process Milestones:

- DY 2:
  - P-1-Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
  - P-2-Establish Baseline Rates Deploy van; enroll 500 new patients; Expect 100% of DY3 enrollees will require treatment for dental caries

Outcome Improvement Targets for each year:

- DY4:
  - IT-7.2 Cavities: Percentage of Children with Untreated Dental Caries

- Enroll an additional 250 patients
- 100% of DY4 enrollees have untreated cavities
- 40% reduction in untreated new cavities for DY3 enrollees

- DY5:
  - IT-7.2 Cavities: Percentage of Children with Untreated Dental Caries
  - Enroll an additional 250 patients
  - 100% of DY5 new enrollees have untreated cavities
  - 60% reduction in untreated new cavities for DY3 enrollees
  - 40% reduction in untreated new cavities for DY4 enrollees

Goals:

	DY3	DY4	DY5
New Patient Enrollment	500	250	250
DY3 Patients Carried Forward		500	500
DY4 Patients Carried Forward			250
Total Patients	500	750	1,000
DY3 Patients Needing Restorative Care	500	300	200
DY4 Patients Needing Restorative Care		250	150
DY5 Patients Needing Restorative Care			250
Total Patients Needing Restorative Care	500	550	600
Percent Patients Restorative Care	100%	73%	60%

Rationale:

Process Milestones P-1 and P-2 were chosen due to the need for extensive due diligence to plan for an effective and efficient mobile dental clinic service. Outcome of this critical needs assessment/referral source development process will drive the Outcome Improvement Targets in DY4 and DY5. The mobile dental clinic is a new service which will help address the oral health needs of underserved urban and rural children of El Paso. In addition to providing cleaning, checkup and restorative services, mobile dental clinic staff will provide intensive, supportive patient education on oral hygiene. Expected outcome is to mitigate future tooth loss, improve nutrition and overall health. DY 2 and DY 3 will be dedicated to the process of business planning; van procurement; staff selection; and initiation of the mobile dental service. By DY 4 of the project the mobile dental clinic should be fully operational and deployed to sites which will ensure full utilization of available appointments and maximize attendant health improvement opportunities for low income, underserved populations. During DY 5 program staff will analyze scope and volume of service and refine procedure offerings and deployment schedule.

The outcome of the proposed DSRIP project will be improved oral health among low income children in underserved urban and rural communities in El Paso County. Specific improvement

targets will be developed as staff analyzes production potential and refines service sites, scheduling, and staffing to maximize community health improvement effect of the mobile dental clinic, i.e., increasing services to vulnerable populations and reducing attendant health disparities.

Project Valuation:

The proposed value (community benefit) of the mobile dental van initiative is $5,933,709 over the DSRIP funding period (DY 2-5). Of that amount $1,011,742 has been allocated for the value of the Category 3 Quality Improvement activities. The valuation takes into account acquisition and outfitting of a mobile dental clinic (amortized over the funding period); direct staffing of the van adjusted for leave time use/staff turnover; supplies/materials/maintenance; back office functions (billing/reporting/human resources); program outreach to assure continuous, productive service sites; program management to troubleshoot scheduling/staffing/production issues; evaluative services for collection and analysis of service/client data relative to planned activity/performance; and administrative leadership. The valuation also reflects additional costs of providing care through a mobile dental clinic v. fixed-site location, e.g., downtime associated with moving the van to multiple sites/van setup results in less production relative to personnel and operating expenses than fixed site. Finally, the valuation estimates the cost avoidance/health status enhancement of providing a regular source of dental care to populations with no prior access to service, e.g., effect of retention of all permanent teeth on improved nutritional intake.

065086301.3.3	*IT-7.2*	*Cavities: Percentage of Children with untreated dental cavities*	
Performing Provider Name: City of El Paso Department of Public Health			*TPI-065086301*
Related Category 1 or 2 Projects:	065086301.1.3		
Starting Point/Baseline:	New Initiative: 0		
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)**
Category 3 **Process Milestone** P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Process Milestone Metric** Goal: Prepare business plan for mobile dental clinic service; spec the van; purchase/outfit the vehicle; recruit staff; cultivate service sites; prepare schedule for deployment Data Source: Purchase /outfitting of van; recruitment of staff; business plan Estimated Incentive Payment: $75,000	**Category 3** **Process Milestone** P-2 Establish Baseline Rates **Process Milestone Metric** Goal: Baseline rate at start of DY3 is determined to be zero (0) as this is a new service. Goal is to enroll 500 new patients by end of DY3. Expect 100% of enrollees will need restorative services. Data Source: Performing Provider Estimated Incentive Payment: $ 289,780	**Category 3** **Outcome Improvement Target** IT-7.2: Goal: Enroll 250 new patients. The number of corrective procedures on patients who completed their initial comprehensive exam and treatment in DY3 will decrease by 40% on their next annual periodic exam due to consistent use of proper oral health practices. Data Source: Performing Provider Estimated Incentive Payment*:* $310,003	**Category 3** **Outcome Improvement Target** IT-7.2: Goal: Enroll 250 new patients. The number of corrective procedures on patients who completed their initial comprehensive exam and treatment in DY3 will decrease by 60% on their next annual periodic exam due to consistent use of proper oral health practices. The number of corrective procedures on patients who completed their initial comprehensive exam and treatment in DY4 will decrease by 40% on their next annual periodic exam due to consistent use of proper oral health practices. Data Source: Performing Provider Estimated Incentive Payment*:* $336,959
Year 2 Estimated Outcome Amount: $75,000	Year 3 Estimated Outcome Amount: $289,780	Year 4 Estimated Outcome Amount: $310,003	Year 5 Estimated Outcome Amount: $336,959
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,011,742			

City of El Paso Department of Public Health
DSRIP Project: Automated Emergency Dispatch System
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target):) IT-9.4 Other Outcome Improvement Target

Unique RHP outcome identification number: 065086301.3.4

Outcome Measure Description:

IT-9.4-Other Outcome Improvement Target
Goal: Reduction in average response time from baseline of 13:24 minutes to 13:09 minutes
Data Source: performing provider

The City of El Paso Department of Public Health is proposing a four year enhancement and improvement of the 911Dispatch system to an Automated System to decrease response time to those in the El Paso area. In the first two years of the project, the health department will be using Process Milestones P-1: Project planning and P: 2 Establish Baseline rates to guide and direct this program. Development will include the purchase and outfitting of the software, equipment, station communication improvements, and response vehicle changes. Training and education of dispatch staff as well as emergency responders will be conducted. An Outcome Improvement plan will be determined from the development of the program. Statistical analyses will be generated on the changes in dispatch times to correct or enhance a positive outcome.

Process Milestones

- DY-2:
  - P-1 Project planning- engage stakeholders identify current capacity and needed resources, determine timelines and document implementation plans
- DY-3:
  - P-2 Establish baseline rates

Outcome Improvement targets for each year:

- DY4:
  - IT 9.4: Other Improvement Target: Average response time of 13:19 minutes

- DY5:

IT 9.4: Other Improvement Target: Average response time of 13:09 minutes

Rationale:

The automated system will enhance the present 911 dispatch system and address the needs to lower the dispatch time in health related emergencies. The expected outcome is to reduce dispatch times and mortality rates with those stricken in an emergency situation. During the DY2 and DY3 period the program will be implemented and modifications will be made to decreasing the 911 "call to on scene care" within the community. By DY4 the projection will have shown an improvement in response times and a noted improvement in health care survivability and quality of life. At DY5 the project will be reanalyzed for improvements.

The Automated Emergency Dispatch System DSRIP project will improve overall community health care to those in need of emergency care in El Paso County. Specific improvement targets will be developed after implementation of the automated dispatch system and analysis of response time.

Outcome Measure Valuation

The value to the community of the Automated Emergency Dispatch System DSRIP project over the course of the funding period is $7,445,616. Of that amount $1,652,117 has been allocated for the value of the Category 3 Quality Improvement activities. The valuation takes into account a complete upgrade of the dispatch system that includes: a new voice automated system, CAD interface, software and hardware systems, audio licenses, training and configuration, station dispatch equipment, and warranty. The proposed project also takes into account the efficiencies of response times and the possible reduction of health costs in the region. Once the automated dispatch system is fully operational, analyses of health care savings can be performed. These analyses will include correlative studies between dispatch/response times and patient acuity upon entry to the hospital.

065086301.3.4	3.IT-9.4	Other Outcome Improvement Target	
Performing Provider Name: City of El Paso Department of Public Health			TPI-065086301
Related Category 1 or 2 Projects:	065086301.1.4		
Starting Point/Baseline:	**Total Response Time of 13:24 Minutes**		
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)**
Category 3 **Process Milestone** P-1 Project planning- engage stakeholders identify current capacity and needed resources, determine timelines and document implementation plans **Process Milestone Metric**: Goal: Identify process improvements, spec complete automated system, prepare rollout plan for new dispatching policy Data Source: Performing Provider: evidence of procurement; system installation; development/implementation of staff training Estimated Incentive Payment: $75,000	**Category 3** **Process Milestone** P-2 Establish baseline rates **Process Milestone Metric**: Goal: Improve current average response time rates of: Dispatch call handling 3:27 min., Turn out time 1:42min., 1st unit arrival travel to scene 7:04min., and total time response 13:34min. for 41,000 runs per year Data Source: Performing Provider: monitoring/tracking system with attendant reports Estimated Incentive Payment*:* $418,080	**Category 3** **Outcome Improvement Target** IT-9.4: Other Outcome Improvement Target: must be evidence based, appropriate for proposed project, and meet the above definition of an outcome measure. Goal: Average response time of 13:19 minutes a. Numerator: Total response time for all runs b. Denominator: Total number of runs estimated at 41,000 c. Data Source: Performing Provider: CAD Computer Aided Dispatch program and Fire Records to run response times and reports; ADAM-Deccan for projection analysis; Intermedix can give medical analysis.	**Category 3** **Outcome Improvement Target** IT-9.4: Other Outcome Improvement Target: must be evidence based, appropriate for proposed project, and meet the above definition of an outcome measure. Goal: Average response time of 13:09 minutes a. Numerator: Total response time for all runs b. Denominator: Total number of runs estimated at 41,000 c. Data Source: Performing Provider: CAD Computer Aided Dispatch program and Fire Records to run response times and

065086301.3.4	3.IT-9.4	Other Outcome Improvement Target	
Performing Provider Name: City of El Paso Department of Public Health			TPI-065086301
Related Category 1 or 2 Projects:	065086301.1.4		
Starting Point/Baseline:	**Total Response Time of 13:24 Minutes**		
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)**
		d. Rationale/Evidence: Improvement in response time will positively impact health status and institutional costs for estimated 20,000 medicaid and uninsured EMS patients. Estimated Incentive Payment*:* $444,959	reports; ADAM-Deccan for projection analysis; Intermedix can give medical analysis. d. Rationale/Evidence: Improvement in response time will positively impact health status and institutional costs for estimated 20,000 medicaid and uninsured EMS patients. Estimated Incentive Payment*:* $714,078
Year 2 Estimated Outcome Amount: $75,000	Year 3 Estimated Outcome Amount: $418,080	Year 4 Estimated Outcome Amount: $444,959	Year 5 Estimated Outcome Amount: $714,078
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,652,117			

City of El Paso Department of Public Health
Pass 2 DSRIP Project: Regional Data Validation of Health Information Exchange
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target):
IT 12.1 Breast Cancer Screening

Unique RHP outcome identification number: 065086301.3.5 Pass 2

Outcome Measure Description:

IT 12.1 Breast Cancer Screening

Goal: Identify approximately 500 Medicaid/uninsured patients in need of primary prevention screening/service (breast cancer screening), and provide necessary preventive service intervention

Data Source: Performing Provider through analysis of HIE data

The City of El Paso Department of Public Health is proposing a four year developmental effort to establish an HIE for the El Paso region which can/will be interfaced with other data repositories for describing health status; and informing researchers, policy makers and service providers. This project, the Regional Data Validation of Health Information Exchange, will help produce a comprehensive database that stores and reports health status date against which future data can be compared.

Through this project, El Paso's policy and practice leaders will be able to make decisions that impact individual and public health using real-time data.

Process Milestones:

- DY 2:
  - P-1 -Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
  - P-3 –Develop and test data systems

Outcome Improvement Targets for each year:

- DY 4:
  - IT 12.1 Breast Cancer Screening
- DY 5:
  - IT 12.1 Breast Cancer Screening

Rationale:

Process Milestones P-1 and P-3 were chosen because of the extensive developmental work that will need to be done to prepare the HIE; market and enroll providers; and interface HIE data with other data repositories, e.g., those contained in the El Paso Community Health Atlas. This preparatory work includes inventorying existing health databases; assessing the capacity to integrate data systems or, otherwise, assure access to the full depth and breadth of health data; identifying gaps in health information, especially as they relate to REAL data collection. The outcome of the preparatory work will drive the Outcome Improvement Target for years DY4 and DY5. These desired outcomes will include development/use of display/reporting models which will improve understanding of area health conditions and inform decision makers on efficient deployment of resources relative to regional and local needs. Project will demonstrate the value of the HIE and its interface with the Atlas by improving preventive services screening/immunization rates for 500 Medicaid/uninsured residents in the select categories of breast cancer screening, colorectal cancer screening, and pneumonia vaccination.

Outcome Measure Valuation:

The proposed value (community benefit) of the Regional Data Validation of Health Information Exchange is $489,675 over the DSRIP funding period (DY 2-5). Of this amount $57,713 has been allocated for the value of Category 3 Quality Improvements. The valuation takes into account direct personnel and operational expenses to support Category 3 activities; costs associated with technical consultation; costs of providing preventive screening/immunization services for uninsured adults in the value demonstration; and the community benefit value of collecting and conducting research on HIE REAL data to describe/refine area health problems with the intent of informing the community of findings; building community constituencies for policy change and program development; and prescribing evidence-based interventions.

065086301.3.5 Pass 2	*3.IT 12.1*	*Breast Cancer Screening*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects	*065086301.1.5 Pass 2*		
Starting Point/Baseline:	*New Initiative: 0*		
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)**
Category 3 Process Milestone P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone Metric Goal: Inform stakeholders and broader community about the Regional Data Validation of Health Information Exchange initiative; assess availability of health data from traditional and non-traditional sources; prepare related index; assess and address issues of inter-operability of databases; identify data gaps. Data Source: Performing Provider Estimated Incentive Payment *:* $1,719	Category 3 Process Milestone P-3 Develop and test data systems Process Milestone Metric Goal: Conduct integrated analysis of existing HIE REAL health data; supplement database, as needed, with biomarker data collected through mobile health screening van and other databases from Community Health Atlas initiative; identify trends and outlier results; begin mapping of results with data overlays; inform stakeholders and broader community of findings and opportunities to develop/implement effective interventions, i.e., describe and prescribe. Data Source: Performing Provider Estimated Incentive Payment: $3,986	Category 3 Outcome Improvement Target IT 12.1 Breast Cancer Screening Goal: Through analysis of HIE database, identify approximately 250 Medicaid/uninsured adults in need of the following preventive health screenings/services: breast cancer screening, provide needed services Data Source: Performing Provider through analysis of HIE data Estimated Incentive Payment*:* $4,264	Category 3 Outcome Improvement Target IT 12.1 Breast Cancer Screening Goal: Through analysis of HIE database, we estimate to identify an additional 250 Medicaid/uninsured adults in need of the following preventive health screenings/services: breast cancer screening, provide needed services Goal: TBD Data Source: Performing Provider Estimated Incentive Payment*:* $9,269

065086301.3.5 Pass 2	*3.IT 12.1*	*Breast Cancer Screening*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects	*065086301.1.5 Pass 2*		
Starting Point/Baseline:	*New Initiative: 0*		
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 Outcome Amount: $1,719	Year 3 Estimated Outcome Amount: $3,986	Year 4 Estimated Outcome Amount: $4,264	Year 5 Estimated Outcome Amount: $9,269
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $19,238			

City of El Paso Department of Public Health
Pass 2 DSRIP Project: Regional Data Validation of Health Information Exchange
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target):
IT 12.3 Colorectal Cancer Screening

Unique RHP outcome identification number: 065086301.3.6 Pass 2

Outcome Measure Description:

IT 12.3 Colorectal Cancer Screening

Goal: Identify approximately 500 Medicaid/uninsured patients in need of primary prevention screening/service, colorectal cancer screening, and provide necessary preventive service intervention

Data Source: Performing Provider through analysis of HIE data

The City of El Paso Department of Public Health is proposing a four year developmental effort to establish an HIE for the El Paso region which can/will be interfaced with other data repositories for describing health status; and informing researchers, policy makers and service providers. This project, the Regional Data Validation of Health Information Exchange, will help produce a comprehensive database that stores and reports health status date against which future data can be compared.

Through this project, El Paso's policy and practice leaders will be able to make decisions that impact individual and public health using real-time data.

Process Milestones:

- DY 2:
  - P-1 -Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
  - P-3 –Develop and test data systems

Outcome Improvement Targets for each year:

- DY 4:
  - IT 12.3 Colorectal Cancer Screening
- DY 5:
  - IT 12.3 Colorectal Cancer Screening

Rationale:

Process Milestones P-1 and P-3 were chosen because of the extensive developmental work that will need to be done to prepare the HIE; market and enroll providers; and interface HIE data with other data repositories, e.g., those contained in the El Paso Community Health Atlas. This preparatory work includes inventorying existing health databases; assessing the capacity to integrate data systems or, otherwise, assure access to the full depth and breadth of health data; identifying gaps in health information, especially as they relate to REAL data collection. The outcome of the preparatory work will drive the Outcome Improvement Target for years DY4 and DY5. These desired outcomes will include development/use of display/reporting models which will improve understanding of area health conditions and inform decision makers on efficient deployment of resources relative to regional and local needs. Project will demonstrate the value of the HIE and its interface with the Atlas by improving preventive services screening/immunization rates for 500 Medicaid/uninsured residents in the select categories of breast cancer screening, colorectal cancer screening, and pneumonia vaccination.

Outcome Measure Valuation:
The proposed value (community benefit) of the Regional Data Validation of Health Information Exchange is $489,675 over the DSRIP funding period (DY 2-5). Of this amount $57,713 has been allocated for the value of Category 3 Quality Improvements. The valuation takes into account direct personnel and operational expenses to support Category 3 activities; costs associated with technical consultation; costs of providing preventive screening/immunization services for uninsured adults in the value demonstration; and the community benefit value of collecting and conducting research on HIE REAL data to describe/refine area health problems with the intent of informing the community of findings; building community constituencies for policy change and program development; and prescribing evidence-based interventions.

065086301.3.6 Pass 2	*3.IT 12.3*	*Colorectal Cancer Screening*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects	*065086301.1.5 Pass 2*		
Starting Point/Baseline:	*New Initiative: 0*		
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)**
Category 3 Process Milestone P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone Metric Goal: Inform stakeholders and broader community about the Regional Data Validation of Health Information Exchange initiative; assess availability of health data from traditional and non-traditional sources; prepare related index; assess and address issues of inter-operability of databases; identify data gaps. Data Source: Performing Provider Estimated Incentive Payment *:* $1,719	Category 3 Process Milestone P-3 Develop and test data systems Process Milestone Metric Goal: Conduct integrated analysis of existing HIE REAL health data; supplement database, as needed, with biomarker data collected through mobile health screening van and other databases from Community Health Atlas initiative; identify trends and outlier results; begin mapping of results with data overlays; inform stakeholders and broader community of findings and opportunities to develop/implement effective interventions, i.e., describe and prescribe. Data Source: Performing Provider Estimated Incentive Payment: $3,986	Category 3 Outcome Improvement Target IT 12.3 Colorectal Cancer Screening Goal: Through analysis of HIE database, identify approximately 250 Medicaid/uninsured adults in need of preventive health screenings/services: colorectal cancer screening; provide needed services Data Source: Performing Provider through analysis of HIE data Estimated Incentive Payment*:* $4,264	Category 3 Outcome Improvement Target IT 12.3 Colorectal Cancer Screening Goal: Through analysis of HIE database, we estimate to identify additional 250 Medicaid/uninsured adults in need of preventive health screenings/services: colorectal cancer screening; provide needed services Goal: TBD Data Source: Performing Provider Estimated Incentive Payment*:* $9,269

065086301.3.6 Pass 2	*3.IT 12.3*	*Colorectal Cancer Screening*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects	*065086301.1.5 Pass 2*		
Starting Point/Baseline:	*New Initiative: 0*		
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 Outcome Amount: $1,719	Year 3 Estimated Outcome Amount: $3,986	Year 4 Estimated Outcome Amount: $4,264	Year 5 Estimated Outcome Amount: $9,269
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $19,238			

City of El Paso Department of Public Health
Pass 2 DSRIP Project: Regional Data Validation of Health Information Exchange
Category 3 Quality Improvements

Title of Outcome Measure (Improvement Target):
IT 12.4 Pneumonia Vaccination

Unique RHP outcome identification number: 065086301.3.7 Pass 2

Outcome Measure Description:

IT 12.4 Pneumonia Vaccination

Goal: Identify approximately 500 Medicaid/uninsured patients in need of primary prevention screening/service, pneumonia vaccination, and provide necessary preventive service intervention

Data Source: Performing Provider through analysis of HIE data

The City of El Paso Department of Public Health is proposing a four year developmental effort to establish an HIE for the El Paso region which can/will be interfaced with other data repositories for describing health status; and informing researchers, policy makers and service providers. This project, the Regional Data Validation of Health Information Exchange, will help produce a comprehensive database that stores and reports health status date against which future data can be compared.

Through this project, El Paso's policy and practice leaders will be able to make decisions that impact individual and public health using real-time data.

Process Milestones:

- DY 2:
  - P-1 -Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
  - P-3 –Develop and test data systems

Outcome Improvement Targets for each year:

- DY 4:
  - IT 12.4 Pneumonia Vaccination
- DY 5:
  - IT 12.4 Pneumonia Vaccination

Rationale:

Process Milestones P-1 and P-3 were chosen because of the extensive developmental work that will need to be done to prepare the HIE; market and enroll providers; and interface HIE data with other data repositories, e.g., those contained in the El Paso Community Health Atlas. This preparatory work includes inventorying existing health databases; assessing the capacity to integrate data systems or, otherwise, assure access to the full depth and breadth of health data; identifying gaps in health information, especially as they relate to REAL data collection. The outcome of the preparatory work will drive the Outcome Improvement Target for years DY4 and DY5. These desired outcomes will include development/use of display/reporting models which will improve understanding of area health conditions and inform decision makers on efficient deployment of resources relative to regional and local needs. Project will demonstrate the value of the HIE and its interface with the Atlas by improving preventive services screening/immunization rates for 500 Medicaid/uninsured residents in the select categories of breast cancer screening, colorectal cancer screening, and pneumonia vaccination.

Outcome Measure Valuation:
The proposed value (community benefit) of the Regional Data Validation of Health Information Exchange is $489,675 over the DSRIP funding period (DY 2-5). Of this amount $57,513 has been allocated for the value of Category 3 Quality Improvements. The valuation takes into account direct personnel and operational expenses to support Category 3 activities; costs associated with technical consultation; costs of providing preventive screening/immunization services for uninsured adults in the value demonstration; and the community benefit value of collecting and conducting research on HIE REAL data to describe/refine area health problems with the intent of informing the community of findings; building community constituencies for policy change and program development; and prescribing evidence-based interventions.

065086301.3.7 Pass 2	*3.IT 12.4*	*Pneumonia Vaccination*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects	*065086301.1.5 Pass 2*		
Starting Point/Baseline:	*New Initiative: 0*		
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)**
Category 3 Process Milestone P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone Metric Goal: Inform stakeholders and broader community about the Regional Data Validation of Health Information Exchange initiative; assess availability of health data from traditional and non-traditional sources; prepare related index; assess and address issues of inter-operability of databases; identify data gaps. Data Source: Performing Provider Estimated Incentive Payment *:* $1,719	Category 3 Process Milestone P-3 Develop and test data systems Process Milestone Metric Goal: Conduct integrated analysis of existing HIE REAL health data; supplement database, as needed, with biomarker data collected through mobile health screening van and other databases from Community Health Atlas initiative; identify trends and outlier results; begin mapping of results with data overlays; inform stakeholders and broader community of findings and opportunities to develop/implement effective interventions, i.e., describe and prescribe. Data Source: Performing Provider Estimated Incentive Payment: $3,986	Category 3 Outcome Improvement Target IT 12.4 Pneumonia Vaccination Goal: Through analysis of HIE database, identify approximately 250 Medicaid/uninsured adults in need of the following preventive health screenings/services: pneumonia vaccination; provide needed services Data Source: Performing Provider through analysis of HIE data Estimated Incentive Payment*:* $4,263	Category 3 Outcome Improvement Target IT 12.4 Pneumonia Vaccination Goal: Through analysis of HIE database, we estimate to identify an additional 250 Medicaid/uninsured adults in need of the following preventive health screenings/services: pneumonia vaccination; provide needed services Goal: TBD Data Source: Performing Provider Estimated Incentive Payment*:* $9,269

065086301.3.7 Pass 2	*3.IT 12.4*	*Pneumonia Vaccination*	
Performing Provider: City of El Paso Department of Public Health			*TPI: 065086301*
Related Category 1 or 2 Projects	*065086301.1.5 Pass 2*		
Starting Point/Baseline:	*New Initiative: 0*		
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 Outcome Amount: $1,719	Year 3 Estimated Outcome Amount: $3,986	Year 4 Estimated Outcome Amount: $4,263	Year 5 Estimated Outcome Amount: $9,269
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $19,237			

Title of Outcome Measure (Improvement Target): IT-6.1: Improvement Over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 2981854201.3.1 Pass 2

Outcome Measure Description

IT – 6.1: Patient Satisfaction Scores

- (2981854201.3.1) - Our goal is to improve patient satisfaction by DY5. Rate of improvement TBD, as we are a new organization and need to determine baseline targets.

To achieve improvement under this metric, EPCH will engage in project planning during DY 2. In DY 3, EPCH will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, EPCH intends to improve its patient satisfaction scores (TBD) over the baseline recorded in DY 3 for the following areas: (1) patients' rating of whether patients are getting timely care, appointments, and information; (2) patients' rating of how well their doctors communicate. In DY 5, EPCH intends to improve its patient satisfaction scores (TBD), over the DY 4 measurement in the same areas. EPCH is a new organization and needs to determine baseline data to determine appropriate targets for improvement.

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-6.1: Percent improvement over baseline of patient satisfaction scores— TBD % improvement over DY3
- DY5:
    - IT-6.1: Percent improvement over baseline of patient satisfaction scores— TBD % improvement over DY4

Rationale:
Currently, there is a shortage of primary care pediatricians in El Paso and statewide that is causing lack of access to care. The pediatrician to child ratio demonstrates that this region is greatly underserved.

Area	Ratio
US Average	1 to 1769
Texas Average	1 to 2421
El Paso Average	1 to 3532

This lack of pediatric primary care capacity, can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. EPCH expects to see an improvement in patient satisfaction as a result of the associated Category 2 project—specifically, an improvement in patients' rating of whether patients are getting timely care, and information, with the implementation of a pediatric hospitalist program.

Another challenge stemming from El Paso's lack of pediatric care capacity is the overburdening of existing pediatricians, meaning that these physicians often do not see inpatients in a timely fashion. As a result, inpatient care is less coordinated and effective than it could be. This challenge will be addressed by EPCH's Implementation of a Pediatric Hospitalist Model project, where EPCH expects to see an improvement in patient satisfaction as a result of the associated Category 2 project—specifically, an improvement in patients' rating of whether patients are getting timely care, and information, and patients' rating of how well their doctors communicate.

Outcome Measure Valuation:
$340,129. The valuation of the EPCH project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether EPCH's related Category 2 project is successful in their goals. The valuation of this outcome measure also takes into account the challenges that EPCH will face in maintaining a patient satisfaction survey system appropriate to the patient populations served.

2981854201.3.1 Pass 2	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
El Paso Children's Hospital			*094109802*
Related Category 1 or 2 Projects:	*2981854201.2.1*		
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: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $40,172	**Process Milestone 2** [P-2]: Establish baseline rates. Baseline / Goal: We anticipate an increase in inpatient patient satisfaction scores on the general pediatric unit (where pediatric Hospitalists oversee patients), by DY5. Our goal will be determined by benchmarking with Press Ganey national database in DY3, comparing children hospitals of similar size. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $46,566	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $74,717	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD% improvement over DY4. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $178,674
Year 2 Estimated Outcome Amount: $40,172	Year 3 Estimated Outcome Amount: $46,566	Year 4 Estimated Outcome Amount: $74,717	Year 5 Estimated Outcome Amount: $178,674
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $340,129			

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: University Medical Center of El Paso
Performing Provider TPI #: 138951211

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – UMC El Paso 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. UMC El Paso expects that its Category 1 projects implementing the provision of expanded primary care services through existing local clinics, and the provision of these services through newly-established clinics, will reduce the number of PPAs over the life of the Waiver. More specifically, UMC El Paso 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 UMC El Paso in this project can offer to a currently underserved patient population. Additionally, UMC El Paso plans to increase the number of primary care providers in El Paso through a Category 1 project to establish a nurse residency program and simulation program; an additional Category 1 project to expand physician residency programs, thus educating more primary care providers and creating opportunities to recruit them to serve the El Paso community for years to come; and two Category 2 projects providing primary and preventive care to residents of El Paso's Salvation Army and Rescue Mission shelters.

- **Valuation**
  - **Rationale/Justification** – The value UMC El Paso 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. UMC El Paso values this reporting domain at $3,496,157 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – UMC El Paso 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. UMC El Paso expects that its Category 1 projects implementing the provision of expanded primary care services through existing local clinics, and the provision of these services through newly-established clinics, will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Additionally, UMC El Paso's Category 1 Psychiatric Liaison Service project will allow inpatients with mental health issues to receive the care they need in the inpatient setting while being treated for non-psychiatric issues, more effectively managing the mental health needs of inpatients and therefore reducing the likelihood that these patients will be readmitted after discharge for mental health reasons. Furthermore, UMC El Paso plans to implement several Category 2 projects with the goal of reducing unnecessary readmissions, including projects which will identify high-risk patients and provide those patients with enhance discharge navigation services; enhance medical homes to ensure that patients have access to adequate community-based follow-up care after discharge; conduct Coumadin medication management programs at UMC El Paso's Neighborhood Health Centers (NHCs); and implement the Chronic Care Management Model in care environments where it has not previously been used. Each of these Category 2 projects will provide post-discharge patients with ongoing health care access that will significantly reduce the need for readmission to the inpatient setting. In general, expanded access to primary care and support at local clinics and related sites of care should have a positive impact on the rate of readmissions to the hospital through the ED.

- **Valuation**
    - **Rationale/Justification** - The value UMC El Paso 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. In the Past, UMC El Paso has been challenged by a significant number of hospitalizations linked to manageable chronic diseases that UMC El Paso intends

to address, in part, with its projects to expand access to primary care. UMC El Paso values this reporting domain at $3,496,157 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – UMC El Paso 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 UMC El Paso is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. UMC El Paso expects that its Category 1 projects to expand access to primary care will reduce the strain on UMC El Paso's hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, UMC El Paso can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. UMC El Paso also plans to implement several Category 1 and 2 projects that will even more specifically target preventable complications in the inpatient setting. One of these Category 1 projects will involve the expansion of access to national databases related to trauma and surgery cases, allowing practitioners to provide more holistic and evidence-based diagnoses and treatments, resulting in continuous quality improvement and facilitating the implementation of lessons learned while reducing errors attributable to incorrect or incomplete diagnoses. Another Category 1 project will enhance performance improvement capacity at UMC El Paso by enhancing the quality improvement infrastructure available at UMC El Paso's NHCs, resulting in the delivery of higher-quality outpatient primary care services at these NHCs. UMC El Paso has also developed a Category 2 project which will provide a Surgery Guidebook and Nurse Advice Line to surgery patients, allowing for greater patient ownership and involvement in the pre-surgery and post-surgery care processes provided at UMC El Paso, which will likely be accompanied by a corresponding reduction in complications, particularly those resulting from a lack of proper patient compliance and coordination with caregivers. The ongoing quality improvement activities which constitute an essential part of many of UMC El Paso's Category 1, 2, and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

- **Valuation**
  - **Rationale/Justification** - The value UMC El Paso 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. UMC El Paso values this reporting domain at $2,414,611 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – UMC El Paso 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. UMC El Paso 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. UMC El Paso expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with UMC El Paso's Category 1 projects to expand primary care access 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). UMC El Paso also believes that its Coumadin medication management project and Surgery Guidebook/Nurse Advice Line project will make significant progress towards the goals of effective medication management and patient-centered care, respectively. UMC El Paso will be measuring patient satisfaction in several of its Category 3 projects in addition to this Category 4 domain.

- **Valuation**
  - **Rationale/Justification** - The value UMC El Paso placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from UMC El Paso and how well UMC El Paso performs its function of promoting medication management. UMC El Paso 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 the El Paso community is costly to patients' health and to the delivery system, and UMC El Paso 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—and UMC's other Category 1, 2, and 3 projects—to have the maximum beneficial impact for the community. UMC El Paso values this reporting domain at $3,496,157 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description –** UMC El Paso 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. UMC El Paso is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. UMC El Paso's Pass 2 project will focus on the entire hospital throughput process and apply LEAN principles in order to reduce our current Ed admit decision time to ED departure time. UMC El Paso also intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which UMC El Paso expects will reduce the number of inappropriate ED visits. Another UMC El Paso Category 2 project will provide complete hospice care for uncompensated patients, further reducing the strain on the community's overburdened emergency departments while increasing patient satisfaction for the population of terminally ill patients that will be served by the project.

- **Valuation**
  - **Rationale/Justification -** The value UMC El Paso 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. UMC El Paso values this reporting domain at $3,496,154 over Demonstration Years 3-5.

Category 4 Table: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- *DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.*
- *Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.*

Category 4: Population-Focused Measures
University Medical Center of El Paso – TPI: 138951211

	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	$2,332,665	$1,081,546		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$1,081,546	$1,157,001	$1,257,610
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$1,081,546	$1,157,001	$1,257,610
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			$1,157,001	$1,257,610
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		$1,081,546	$1,157,001	$1,257,610
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		$1,081,545	$1,157,000	$1,257,609
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
IGT Entity for State Share	UMC El Paso	UMC El Paso	UMC El Paso	UMC El Paso
State Share of Category 4 (est. using FMAP of 60%)	$933,066	$2,163,012	$2,314,002	$2,515,220
Grand Total Payments Across Category 4	$2,332,665	$5,407,729	$5,785,004	$6,288,049

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: HCA Las Palmas Del Sol
Performing Provider TPI #: 094109802

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – LPDS 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. LPDS plans to implement several Category 1 DSRIP projects which share the goal of addressing the root causes of potentially preventable admissions. Specifically, these projects include a Physician and Mid-Level Recruitment and Training project which is intended to adopt new and innovative methods of recruiting much-needed primary care providers to the El Paso community; LPDS expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. LPDS will also expand El Paso's primary care capacity by offering more women's imaging services in the community, allowing potentially harmful and expensive health conditions to be detected and treated early and inexpensively.

- **Valuation**
  - **Rationale/Justification** – The value LPDS has 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 LPDS will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. LPDS values this reporting domain at $1,184,247 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – LPDS 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. LPDS expects that its improvement

of access to primary care services through recruiting and training of additional primary care providers will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Additionally, LPDS plans to implement a wide variety of other Category 1, 2, and 3 projects which will directly target potentially preventable readmissions, including projects to expand inpatient psychiatric telemedicine services, develop and implement a diabetes management registry, evaluate the impact of hospitalists in an inpatient setting, develop electronic medical records to allow for better coordination of care before and after discharge, streamline the discharge process, and reduce readmission rates for health conditions such as diabetes and congestive heart failure.

- **Valuation**
    - **Rationale/Justification -** The value LPDS 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 (e.g., diabetes and congestive heart failure) 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 at LPDS will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. LPDS values this reporting domain at $1,184,247 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – LPDS 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 LPDS is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. LPDS expects that its implementation of the use of electronic medical records throughout its facility, and its potential implementation of a hospitalist model of inpatient care, will together result in more effective, higher quality care being provided to inpatients. The ongoing quality improvement activities which constitute an essential part of many of LPDS's Category 1, 2, and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

- **Valuation**

- **Rationale/Justification** - The value LPDS 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. LPDS values this reporting domain at $817,897 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – LPDS 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. LPDS 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. LPDS expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with LPDS's projects to strengthen primary care access in the El Paso community and to implement databases or programs to promote and facilitate management of chronic conditions such as diabetes and congestive heart failure, 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 LPDS placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from LPDS and how well LPDS performs its primary care and post-discharge functions. LPDS 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 El Paso is costly to patients' health and to the delivery system, and LPDS 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 El Paso community. LPDS values this reporting domain at $1,118,247 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – LPDS 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. LPDS is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. This reporting domain ties in with one of LPDS's overall goals and one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. LPDS intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the El Paso community, and to improve follow-up care for discharged patients facing chronic health conditions such as diabetes and congestive heart failure, which LPDS expects will reduce the number of inappropriate ED visits.

- **Valuation**
  - **Rationale/Justification** - The value LPDS 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. LPDS values this reporting domain at $1,118,246 over Demonstration Years 3-5.

Category 4 Table: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- *DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.*
- *Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.*

Category 4: Population-Focused Measures
LPDS – TPI: 094109802

	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	$790,139	$366,350		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$366,350	$391,909	$425,988
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$366,350	$391,909	$425,988
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			$391,909	$425,988
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		$366,350	$391,909	$425,988
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		$366,349	$391,909	$425,988
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
IGT Entity for State Share	UMC El Paso	UMC El Paso	UMC El Paso	UMC El Paso
State Share of Category 4 (est. using FMAP of 60%)	$316,056	$732,699	$783,818	$851,976
Grand Total Payments Across Category 4	$790,139	$1,831,748	$1,959,545	$2,129,940

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Providence Memorial Hospital
Performing Provider TPI #: 130601104

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Providence 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. Providence expects that its provision of expanded primary and specialty care services under two of its Category 1 projects will reduce the number of PPAs over the life of the Waiver. More specifically, Providence 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 and specialty care providers participating with Providence in this project can offer to a currently underserved patient population.

- **Valuation**
  - **Rationale/Justification** – The value Providence 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Providence intends to address with its Category 1 projects to expand access to primary care and specialty care. Providence values this reporting domain at $570,274 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Providence 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. Providence expects that its

provision of expanded primary care and specialty care services through 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, Providence's Category 2 Care Transitions Programs project relates to this reporting domain because patients who are supported by Care Transitions Programs will be less likely to require inpatient care subsequent to discharge. Expanded access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

- **Valuation**
    - **Rationale/Justification -** The value Providence 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Providence values this reporting domain at $570,274 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Providence 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 Providence is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Providence expects that its Category 1 projects to expand access to primary care and specialty care will reduce the strain on Providence's hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Providence can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Providence's Category 1, 2, and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

- **Valuation**

- **Rationale/Justification** - The value Providence 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. Providence values this reporting domain at $393,858 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Providence 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. Providence 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. Providence expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Providence's Category 1 project to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they 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 Providence placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Providence and how well Providence performs its function of promoting medication management. Providence 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 the El Paso community is costly to patients' health and to the delivery system, and Providence 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.

Providence values this reporting domain at $570,274 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – Providence 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. Providence is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Pursuant to two of its Category 1 projects, Providence intends to expand access to primary care and specialty care for patients who currently are unable to access primary care due to their financial situation, which Providence expects will reduce the number of inappropriate ED visits.

- **Valuation**
  - **Rationale/Justification** - The value Providence 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. Providence values this reporting domain at $570,273 over Demonstration Years 3-5.

Category 4 Table: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- *DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.*
- *Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.*

Category 4: Population-Focused Measures
Providence Memorial Hospital – TPI: 130601104

	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	$380,491	$176,416		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$176,416	$188,724	$205,135
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$176,416	$188,724	$205,135
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			$188,724	$205,135
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		$176,416	$188,724	$205,135
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		$176,415	$188,724	$205,134
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
IGT Entity for State Share	UMC El Paso	UMC El Paso	UMC El Paso	UMC El Paso
State Share of Category 4 (est. using FMAP of 60%)	$152,196	$352,831	$377,448	$410,269
Grand Total Payments Across Category 4	$380,491	$882,078	$943,619	$1,025,672

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Sierra Providence East Medical Center
Performing Provider TPI #: 196829901

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Sierra East 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. Sierra expects that its provision of expanded primary and specialty care services under two of its Category 1 projects will reduce the number of PPAs over the life of the Waiver. More specifically, Sierra East 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 and specialty care providers participating with Sierra East in this project can offer to a currently underserved patient population.

- **Valuation**
  - **Rationale/Justification** – The value Sierra East 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Sierra East intends to address with its Category 1 projects to expand access to primary care and specialty care. Sierra East values this reporting domain at $320,180 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Sierra East 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. Sierra expects that its provision of

expanded primary care and specialty care services through 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, Sierra East's Category 2 Care Transitions Programs project relates to this reporting domain because patients who are supported by Care Transitions Programs will be less likely to require inpatient care subsequent to discharge. Expanded access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

- **Valuation**
  - **Rationale/Justification -** The value Sierra East 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Sierra East values this reporting domain at $320,179 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Sierra East 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 Sierra East is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Sierra East expects that its Category 1 projects to expand access to primary care and specialty care will reduce the strain on Sierra East's hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Sierra East can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Sierra East's Category 1, 2, and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

- **Valuation**
  - **Rationale/Justification -** The value Sierra East 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. Sierra East values this reporting domain at $221,131 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Sierra East 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. Sierra East 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. Sierra East expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Sierra East's Category 1 project to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they 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 Sierra East placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Sierra East and how well Sierra East performs its function of promoting medication management. Sierra East 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 the El Paso community is costly to patients' health and to the delivery system, and Sierra East 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. Sierra East values this reporting domain at $320,180 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description –** Sierra East 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. Sierra East is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Pursuant to two of its Category 1 projects, Sierra East intends to expand access to primary care and specialty care for patients who currently are unable to access primary care due to their financial situation, which Sierra East expects will reduce the number of inappropriate ED visits.

- **Valuation**

Rationale/Justification - The value Sierra East 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. Sierra East values this reporting domain at $320,180 over Demonstration Years 3-5.

Category 4 Table: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- *DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.*
- *Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.*

Category 4: Population-Focused Measures
Sierra Providence East Medical Center – TPI: 196829901

	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	$213,626	$99,048		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Domain 1 - Estimated Maximum Incentive Amount		$99,048	$105,959	$115,173
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Domain 2 - Estimated Maximum Incentive Amount		$99,048	$105,959	$115,173
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			$105,959	$115,173
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		$99,048	$105,959	$115,173
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		$99,048	$105,959	$115,173
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
IGT Entity for State Share	UMC El Paso	UMC El Paso	UMC El Paso	UMC El Paso
State Share of Category 4 (est. using FMAP of 60%)	$85,450	$198,096	$211,918	$230,345
Grand Total Payments Across Category 4	$213,626	$495,241	$529,794	$575,863

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: El Paso Children's Hospital
Performing Provider TPI #: 2981854201

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – El Paso Children's will report on the 8 measures in this domain (those that have large enough populations for any given measure to produce statistically significant valid data), 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. El Paso Children's expects that unnecessary admissions will be reduced as new admissions processes are put into place under El Paso Children's Category 1 and 3 projects. El Paso Children's expects these projects to benefit underserved populations in the El Paso community which may utilize the ED at a higher rate than other populations due to their lack of access to primary and specialty care in a non-emergent setting.

- **Valuation**
  - **Rationale/Justification** – The value El Paso Children's 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. El Paso Children's values this reporting domain at $37,628 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** –El Paso Children's will report on the 7 measures in this domain (those that have large enough populations for any given measure to produce statistically significant valid data), 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. El Paso Children's expects that the implementation of its Category 1 and 3 projects may result in

higher quality care provided to ED patients, perhaps reducing the likelihood of long-term complications requiring readmissions for these patients.

- **Valuation**
  - **Rationale/Justification** - The value El Paso Children's 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 the El Paso community will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. El Paso Children's values this reporting domain at $37,630 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – El Paso Children's will report on the 64 measures in this domain (those that have large enough populations for any given measure to produce statistically significant valid data), 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 El Paso Children's is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. El Paso Children's expects that its Category 1 and 3 projects will improve the efficiency, quality, and timeliness of care in the ED, thereby reducing the strain on El Paso Children's hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, El Paso Children's 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 El Paso Children's 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. El Paso Children's values this reporting domain at $25,989 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – El Paso Children's 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. El Paso Children's 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. El Paso Children's expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with El Paso Children's Category 1 and 3 projects to improve the patient experience for ED patients. 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 El Paso Children's placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from El Paso Children's and how well El Paso Children's performs its function of promoting medication management. El Paso Children's 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 the El Paso community is costly to patients' health and to the delivery system, and El Paso Children's 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. El Paso Children's values this reporting domain at $37,630 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – El Paso Children's 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. El Paso Children's is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. This reporting domain directly ties in with El Paso Children's Category 3 outcome to reduce length of stay (LOS) in the ED.

- **Valuation**
  - **Rationale/Justification -** The value El Paso Children's 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. El Paso Children's values this reporting domain at $37,631 over Demonstration Years 3-5.

Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures (13 measures)

- **Description -** El Paso Children's will report on CMS' Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. El Paso Children's is committed to providing quality care to all patients, regardless of ability to pay. Accordingly, El Paso Children's has developed and plans to implement Category 1 and 3 projects which will serve the common need of the El Paso community's diverse patient populations for quality and effective care. More specifically, the tracking and reporting of this domain's measures for children will enable El Paso Children's to perform more effectively its core mission of providing health care to children in the El Paso community.
- **Valuation Rationale/Justification –** The value El Paso Children's placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices. Understanding our starting point and tracking our improvement is essential to making progress. El Paso Children's values this reporting domain at $37,631 over Demonstration Years 3-5.

Category 4 Table: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- *DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.*
- *Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.*

Category 4: Population-Focused Measures
El Paso Children's Hospital – TPI: 2981854201

	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	$20,086	$11,641		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$11,641	$12,452	$13,535
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$11,641	$12,453	$13,536
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			$12,453	$13,536
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		$11,641	$12,453	$13,536
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		$11,642	$12,453	$13,536
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		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
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		$11,642	$12,453	$13,536
IGT Entity for State Share	UMC El Paso	UMC El Paso	UMC El Paso	UMC El Paso
State Share of Category 4 (Calculated from Pass 2 Workbook)	$8,175	$28,854	$30,864	$33,551
Grand Total Payments Across Category 4	$20,086	$69,848	$74,717	$81,215

Category 4 Population-Focused Improvements

UC-Only Hospital: Sierra Medical Center
TPI #: 133245406

Sierra Medical Center ("Sierra") intends to participate in the Waiver as a UC-only hospital, but is not presently participating in DSRIP for DY2. As a result, Sierra will report on Category 4 measures, as required of hospitals participating in the UC pool in accordance with Section 8 of the Program Funding and Mechanics Protocol ("PFM Protocol"). Sierra understands that this reporting is a condition of participation in the UC Waiver pool. Based on HHSC guidance, and Sierra's inability to receive DSRIP funding for its Category 4 reporting (in accordance with Section 8 of the PFM Protocol), Sierra does not believe that it is required to submit a Category 4 Narrative or Table. Please notify Sierra if there are additional requirements for UC-only hospitals, as Sierra is anxious to participate fully in the UC pool.

Sierra will use a reporting period from October 1 – September 30 to be consistent with Waiver program years, and will submit a report during the semi-annual reporting period #1 (October 1 – March 31).

Category 4 Population-Focused Improvements

UC-Only Hospital: El Paso Psychiatric Center
TPI #: 112751605

El Paso Psychiatric Center ("EPPC") intends to participate in the Waiver as a UC-only hospital, but is not presently participating in DSRIP for DY2. As a result, EPPC will report on Category 4 measures, as required of hospitals participating in the UC pool in accordance with Section 8 of the Program Funding and Mechanics Protocol ("PFM Protocol"). EPPC understands that this reporting is a condition of participation in the UC Waiver pool. Based on HHSC guidance, and EPPC's inability to receive DSRIP funding for its Category 4 reporting (in accordance with Section 8 of the PFM Protocol), EPPC does not believe that it is required to submit a Category 4 Narrative or Table. Please notify EPPC if there are additional requirements for UC-only hospitals, as EPPC is anxious to participate fully in the UC pool.

EPPC will use a reporting period from October 1 – September 30 to be consistent with Waiver program years, and will submit a report during the semi-annual reporting period #1 (October 1 – March 31).