Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

1-31-12

RHP 14/Regional Healthcare Partnership Region 14

RHP Lead Contact: *John O'Hearn, MHA*
Director of Regional Development
1115 Waiver Region 14 Anchor Contact
Medical Center Health System
500 W. 4th St. Odessa, TX 79761
johearn@echd.org
Office 432-640-2429
Fax 432-640-1118

Table of Contents

Instructions 1

Section I. RHP Organization 3

Section II. Executive Overview of RHP Plan 8

Section III. Community Needs Assessment 27

Section IV. Stakeholder Engagement 46
- A. RHP Participants Engagement 46
- B. Public Engagement 47

Section V. DSRIP Projects 49
- A. RHP Plan Development 49
- B. Project Valuation 50
- C. Category 1: Infrastructure Development 52
- D. Category 2: Program Innovation and Redesign 203
- E. Category 3: Quality Improvements 395
- F. Category 4: Population-Focused Improvements (Hospitals only) 591

Section VI. RHP Participation Certifications 618

Section VII. Addendums 620

Instructions

Supporting Documents: RHPs shall refer to Attachment I (RHP Planning Protocol), Attachment J (RHP Program Funding and Mechanics Protocol), the Anchor Checklist, and the 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.

Timeline:

HHSC Receipt Deadline	What to submit	How to submit
10:00 am Central Time, October 31, 2012	Sections I, II, & III of the RHP Plan & Community Needs Supplemental Information	Submit electronically to HHSC Waiver Mailbox
5:00 pm Central Time, November 16, 2012	Pass 1 DSRIP (including applicable RHP Plan sections, Pass 1 Workbook, & Checklist)	Mail to address below
5:00 pm Central Time, December 31, 2012	Complete RHP Plan (including RHP Plan, Workbooks, & Checklist)	Mail to address below

All submissions will be date and time stamped when received. It is the RHP's responsibiility to appropriately mark and deliver the RHP Plan to HHSC by the specified date and time.

Submission Requirements: All sections are required unless indicated as optional.

The Plan Template, Financial Workbook, and Anchor Checklist must be submitted as electronic Word/Excel files compatible with Microsoft Office 2003. RHP Plan Certifications and Addendums must be submitted as PDF files that allow for OCR text recognition. Please place Addendums in a zipped folder.

You must adhere to the page limits specified in each section using a minimum 12 point font for narrative and a minimum 10 point font for tables, or the RHP Plan will be immediately returned.

Mailed Submissions: RHP Packets should include one CD with all required electronic files and two hardbound copies of the RHP Plan (do not include hardbound copies of the finanical workbook).

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

Communication: 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.

Section I. RHP Organization

Please list the participants in your RHP by type of participant: Anchor, IGT Entity, Performing Provider, Uncompensated Care (UC)-only hospital, and other stakeholder, including the name of the organization, lead representative, and the contact information for the lead representative (address, email, and phone number). The lead representative is HHSC's single point of contact regarding the entity's participation in the plan. Providers that will not be receiving direct DSRIP payments do not need to be listed under "Performing Providers" and may instead be listed under "Other Stakeholders". Please provide accurate information, particularly TPI, TIN, and ownership type; otherwise there may be delays in your payments. Refer to the Companion Document for definitions of ownership type. Add additional rows as needed.

Note: HHSC does not request a description of the RHP governance structure as part of this section.

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)*						
Hospital District	135235306	17523029282501	Non-State Public	Ector County Hospital District dba Medical Center Health System	John O'Hearn, Director of Regional Development	500 W. 4th St. Odessa, TX 79761 johearn@echd.org 432-640-2429
IGT Entities *(specify type of government entity, e.g. county, hospital district)*						
Hospital District	112684904	17523018012002	Non-State Public	Reeves County Hospital District	Lorenzo Serrano	2323 Texas Street Pecos, TX 79772

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)
						lorenzos@trhta.net 432-447-3551 ext. 6325
Hospital District	127298103	17519978807000	Non-State Public	Andrews County Hospital District dba Permian Regional Medical Center	Sandra Cox, CFO	PO Box 2108 Andrews, TX 79714 scox@permianregional.com 432-464-2107
Hospital District	136143806	17515845596000	Non-State Public	Midland County Hospital District dba Midland Memorial Hospital	Russell Meyer, CEO	400 Rosalind Redfern Grover Parkway Midland TX 79701 Russell.meyers@midland-memorial.com 432-221-1584
Hospital District	136145310	17513001051555	Non-State Public	Martin County Hospital District	Rance Ramsey, CNO	600 Interstate 20 East P.O. Box 640 Stanton, Texas 79782 rramsey@martinch.org (432) 607-3207 (ext. 3207)
Hospital District	094172602	17512461660002	Non-State Public	McCamey County Hospital District	Jodie Gulihur, CFO	2500 S Hwy 305 McCamey, TX 79752 jgulihur@mchdtx.net 432-652-8626
Hospital District	176354201	17417363466006	Non-State Public	Culberson County Hospital District	Becky Brewster	PO Box 1145 Van Horn, TX 79855 brewster@valornet.com (432) 207-0346
Hospital District	199602701	13523365016	Non-State Public	Crane County Hospital District	Dianne Yeager	1310 South Alford Street Crane, Texas 79731 dyeager@cranememorial.com 432-558-3555
Physician Practice affiliated	081939301	37397397391019	State Owned	Texas Tech	Kandy Stewart	800 W. 4th Street

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)
with an Academic Health Science Center (AHSC)				University Health Science Center-Permian Basin		Odessa TX 79763 kandy.stewart@ttuhsc.edu 432-335-5190
County	094204701	17560012027014	Non-State Public	Winkler County	Jeanna Wilhelm	PO Drawer Y Kermit, TX 79745 Jeanna.willhelm@co.winkler.tx.us (432) 586-6658
CMHC	138364812	17514017767014	Non-State Public	Permian Basin Community Centers	Ramona Thomas, CFO	401 E. Illinois Midland, TX 79701 rthomas@pbmhmr.com 432-570-3333
CMHC	130725806	17526061696003	Non-State Public	West Texas Centers	Gail Wells	409 Runnels Big Spring, Texas 79720 Gail.wells@wtcmhmr.org 432-466-1504
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	176354201	12013552562005	Private	Culberson Hospital	Jared Chanski, CEO	PO Box 609 Van Horn, TX 79855 jchanski@culbersonhospital.org 432-283-2760

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)
Private Hospital	112711003	16217955745001	Private	Odessa Regional Medical Center	Stacey Gerig, CEO	520 East Sixth Street Odessa, Texas 79761 SGerig@iasishealthcare.com 432-582-8703
Private Hospital	094204701	17560012027014	Non-State Public	Winkler County Memorial Hospital	William Ernst, CEO	821 Jeffee Dr Kermit, TX wernst@wcmh.net 432-586-8257
UC-only Hospitals *(list hospitals that will only be participating in UC)*						
Private Hospital	131043506	17525745810000	Private	Scenic Mountain Medical Center	John Irby, CFO	1601 West Eleventh Place Big Spring, TX 79720 John_irby@chs.net 432-268-4904
Private Hospital	094224503	17527175453005	Private	Big Bend Regional Medical Center	Michael Ellis, CEO	2600 Hwy 118 N Alpine, TX Mike_ellis@chs.net 432-837-0242
Public Hospital (County)	136331910	75 6001193	Non-State Public	Ward Memorial Hospital	Padraic White, CEO	PO Box 40 Monahans, TX 79756 pwhite@wardmemorial.org 432-943-2511 ext. 174
Hospital District	199602701	13523365016	Non-State Public	Crane County Hospital District	Dianne Yeager, CEO	1310 South Alford Street Crane, Texas 79731 dyeager@cranememorial.com 432-558-3555
State Hospital	137918204	13201136432000	State-Owned	Big Spring State Hospital	Olga Rodriguez	1100 West 49th St. Austin, TX 78756 Olga.rodriguez@dshs.state.tx.us

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)
						512-776-7181
Other Stakeholders *(specify type)*						
County Medical Associations/Societies						
Regional Public Health Directors						
Other significant safety net providers within the region (specify type)						
Others (specify type, e.g. advocacy groups, associations)						

Section II. Executive Overview of RHP Plan

RHP 14's vision since the beginning of this project has been to ensure that all patients in this region have access to high quality medical and behavioral healthcare services regardless of socioeconomic income or location. We understand that this is a community effort and we are working diligently with our different stakeholders to ensure that we can accomplish our goals. We are working to ensure that patients have options outside of the traditional inpatient setting, by revamping outpatient procedures and guidelines.

- ***High-level summary of existing RHP healthcare environment, which may include a brief summary of the RHP's patient population and health system***
    - *RHP 14 has a very unique healthcare environment. Due to our size, many of our patients are traveling great distances to get specialty services and in some cases even primary care. This leads to very low rates in terms on proper screenings, prenatal care, and health literacy. Another unique factor is that we don't have one large system like you would see in East Texas or more urban areas. We are a collection of independent entities that have operated in silos and therefore care became poorly coordinated. Through the waiver process we were able to identify ways in which we can work together to streamline care and through our projects you will find numerous examples of entities working together. We are also a very rapidly growing segment of Texas. Midland and Odessa are the two fastest growing cities in the US according to multiple reports and that doesn't even take into account the estimated 20,000-30,000 people we have living in hotels waiting for housing to come available. This rapidly changing environment has put a strain on already limited resources and space, which we believe leads to improper utilization of emergency services and resources.*
    - *Patient Population facts and figures:*
        - *According to our CNA, twenty-six percent of adults 25 years or older in RHP 14 did not graduate from high school. About 28% have some kind of college degree. Eighteen percent of all people in the RHP fall below the poverty line. The percentage of children living in poverty is 26%.*
        - *The overall teen pregnancy rate in RHP 14 was higher (29.4/1000) than the Texas rate of 21.4/100.*
        - *10 of the 16 counties in RHP 14 are considered Frontier Counties because they have less than seven people per square mile.*
        - *40% of people living in RHP 14 have commercial insurance.*
        - *29% are uninsured, and the remainder relies on Medicare, Medicaid, or CHIP.*
        - *13 out of 16 Counties are designated as Medically Underserved Areas.*
        - *RHP 14 has higher death rates than Texas for heart disease, chronic lower respiratory disease, accidents, Alzheimer's disease, motor vehicle accidents, influenza/pneumonia, and cancers of colon, rectum, anus, and suicide.*
- ***Key health challenges facing the RHP***

- *Rapid Population Growth- the Texas State Data Center and Office of the State Demographer estimated the population in 2012 to be 385,144. According to their estimates, the population will increase by 10% from 2012 to 2030, growing from 385,144 to 424,968. People aged 65 and older will account for a larger percentage of the population in 2030.*
- *Limited Available Housing- This is directly related to the population growth. Findings homes for incoming healthcare professionals is very difficult.*
- *Provider shortages- We have an aging physician base in RHP 14 and recruitment of providers is sometimes difficult, especially in the frontier counties.*

- ***High level summary of how the 4-year DSRIP projects realize the RHP's 5-year vision***
  - *Primary Care Expansion- RHP 14 understands that our current primary care infrastructure is insufficient to meet our current needs. Almost every entity in RHP 14 has dedicated a project or segment of a project to meet this need.*
  - *Health Literacy rates in our area are very low, so to impact that you will see numerous education projects, as well as interpretation projects aimed at eliminating that specific barrier to care.*
  - *Community involvement is of paramount importance to our long term success as a region. We have projects that bring together different counties entities to tackle chronic disease. Regional partners include school districts, health departments, community colleges, and medical societies. By working together in a substantive way, we believe that our projects will have an even greater impact.*

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			
135235306.1.1-**West Odessa Family Health Clinic** Medical Center Health System 135235306	Establishing a primary care medical home in the underserved area of West Odessa. Focus would be on pediatrics, family practice, optometry, and OB/GYN.	135235306.3.1- IT 1.10 Diabetes care: HbA1c poor control (>9.0%)	$8,701,783
135235306.1.2 **MCHS Healthy Kids Program** Medical Center Health System 135235306	Establishing a pediatric program designed to increasing health literacy and improves access to pediatric services.	135235306.3.2 IT 3.11 Pediatric Asthma 30-Day readmission rate	$8,658,623

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**
135235306.1.3 **MCHS Women's Health Initiative** Medical Center Health System 135235306	Improving access to all expectant mothers and piloting new care models to deliver care.	135235306.3.3 IT 8.3 Early Elective Delivery	$8,301,010
135235306.1.4 MCHS **Interpretation Expansion** Medical Center Health System 135235306	Improving interpretation services through technology and increased training therefore ensuring that all patients are able to understand discharge instructions.	135235306.3.4 IT 6.1 Patient Satisfaction	$1,813,738
136143806.1.1: - **Expanded Primary Care** Midland Memorial Hospital 136143806	Our Region has only 61 primary care physicians per 100,000 people, compared to the state-wide rate of 69.5. HHS has designated all the counties in RHP14 as having "whole" or "partial" shortages of primary care physicians. Our recruitment project focuses on family practitioners, pediatricians, and mid-level (APRN and/or PA) primary care providers which will allow Midland residents greater access to basic health care. Our goal is to increase the number of primary care providers in RHP 14 by recruiting at least 2 additional providers per year for the extent of the demonstration project thereby increasing access to basic healthcare and increased treatment of high blood pressure issues that affect 33.5% of the population.	136143806.3.1- IT 1.7- Controlling high blood pressure	$5,627,235

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**
136143806.1.2: **68NURSE Expansion** Midland Memorial Hospital: 136143806	In an effort to improve appropriate utilization of ED services, the 68NURSE telephone triage program was developed to provide medical advice to community residents. Our goal is the expansion of this program. Included in our expansion plans is developing linkages between the triage service and one or more local primary care providers. By using established protocols, patients are triaged based on their chief complaint and associated signs or symptoms to the most appropriate level of care.	136143806.3.2- IT 9.2- ED appropriate utilization	$3,094,979
136143806.1.3: **Establishment of Women's Clinic in an Underserved Area** Midland Memorial Hospital 136143806	To establish a new clinic solely for women's health within an existing medical clinic. MCHS' Coleman Clinic is located in a medically-underserved area of Midland. The target clientele are generally young, low-income and uninsured. For many of the patients, educational, cultural and language barriers may discourage timely access to pregnancy testing and early prenatal care. We want to remove the barriers to obstetrical care for low-income women in this medically-underserved area of Midland and improve access to first	136143806.3.3- IT 8.2- % of Low-Birth Weight Births	$3,376,341

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**
	trimester prenatal care.		
136143806.1.4:**Enhance Interpretation Services and Culturally Competent Care: Expansion of Remote Video/Voice Interpretation Services** Midland Memorial Hospital 136143806	Our goal is to increase the number of qualified medical interpreters and to expand video/voice LAS services with our hospital thereby enhancing effective communication with LEP patients and their families. Effective and expedient communication facilitates mutual understanding of assessment, appropriate diagnosis, agreeable treatment options and acute or chronic illness education transcending to compliance with treatment plans, better patient satisfaction scores and lower readmission rates.	136143806.3.4- IT 3.1- All Cause 30 Day Readmission Rate	$3,094,979
136143806.1.5: **Expand Specialty Care Capacity: Recruiting targeted specialty care providers to RHP14** Midland Memorial Hospital 136143806	Our goal is to increase the number of targeted specialty care providers in Midland by recruiting at least one (1) additional targeted specialist per year for the extent of the demonstration project thereby allowing Midland residents greater access to specialty health care. Our primary challenges include cost involved in recruitment; the competitive nature of recruiting the limited number of available physicians to a remote community; the need of providers to be bilingual	136143806.3.5- IT 11.1- Improvement in Clinical Indicator in identified disparity group	$3,657,703

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**
	in Spanish/English; and, with the energy-related economic boom, housing has become very limited.		
081939301.1.1: **Expansion of Behavior Health Sciences** Texas Tech University Health Science Center-Permian Basin 081939301	Improved access to psychiatric care and services in RHP 14 through the recruitment of new physicians.	081939301.3.1- IT-2.4- Behavior Health/Substance Abuse	$3,491,398
081939301.1.2: **VIP Relationships in the Home** Texas Tech University Health Science Center-Permian Basin 081939301	Our residency program will appropriately train physicians for RHP 14 in a Patient Centered Medial Home (PCMH) model stressing relationships, and establishment of a Regional Network Relationship (RNR) of physicians and patients.	081939301.3.2- IT 6.1 Patient Satisfaction	$3,415,496
081939301.1.3: **Family Medicine Rural Track** Texas Tech University Health Science Center-Permian Basin 081939301	The Texas Tech Family Medicine Rural Track-Permian Basin (TTFMRT-PB) will be developed by the Texas Tech University Health Sciences Center Family and Community Medicine Department at the Permian Basin and submitted for approval by the ACGME. Rural Clinic assessment, IT support, and the development of Telemedicine between Alpine, Texas and Ft. Stockton, Texas (RHP 13) (Pecos County) and TTUSHC-SOM Permian Basin will also occur	081939301.3.3- IT-9.2- ED Appropriate Utilization	$4,098,595

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**
081939301.1.4: **Identification and Intervention to address local gaps in women's healthcare through education** Texas Tech University Health Science Center-Permian Basin 081939301	Address regional gaps in women's access to healthcare through the increase of infrastructure dedicated to provision of healthcare for women in the Permian Basin through increased staffing, geographic expansion of obstetric and gynecologic care within the region and collaboration with community agencies and providers.	081939301.3.4- IT 12.1- Breast Cancer Screenings 081939301.3.5- IT 12.1- Cervical Cancer Screenings 081939301.3.6- IT 12.5- Reductions in second teen pregnancy	$3,263,696
094204701.1.1: **Primary Care Expansion** Winkler County Memorial Hospital 094204701	Primary Care Expansion to accommodate growing population	094204701.3.1- IT 9.2- ED Appropriate Utilization	$356,968
127298103.1.1: **Establishment of Prompt Care Center** Permian Regional Medical Center 127298103	Primary Care Expansion focused on providing Prompt Care Services for the residents of Andrews County.	127298103.3.1- IT 9.2- ED Appropriate Utilization	$3,311,023
112711003.1.1: **Expansion of Primary Care Access** Odessa Regional Medical Center 112711003	ORMC will expand access to primary care through the recruitment and establishment of two additional primary care physicians along with increasing hours of operation at identified locations. ORMC hopes to demonstrate these goals through increased satisfaction scores regarding timeliness of care and appointments.	112711003.3.1- IT 6.1- Percent improvement over baseline of patient satisfaction scores; getting timely care, appointments, and information.	$5,014,112
112711003.1.2: **Implementation of Mobile Clinic**	Develop a mobile clinic to increase access to primary care services to populations that	112711003.3.2- IT 12.5 Other USPSTF endorsed screening outcome	$4,512,700

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**
Odessa Regional Medical Center 112711003	might otherwise go without. Evidence of this will be demonstrated through the increase in carotid artery Stenosis, peripheral arterial disease, and abdominal aortic aneurysm screenings offered.	measure 112711003.3.3- IT 12.5 Other USPSTF endorsed screening outcome measure 112711003.3.4- IT 12.5 Other USPSTF endorsed screening outcome measure	
112711003.1.3: **Development of Telemedicine Program** Odessa Regional Medical Center 112711003	Develop a telemedicine program and identify services most needed within the RHP. Currently ORMC is exploring a neuro-telemedicine program due to the importance of timely identification and treatment associated with stroke.	112711003.3.5- IT 3.7- Stroke/CVA 30 Day Readmission Rate	$2,507,056
112711003.1.4: **Gestational Diabetes Management Program** Odessa Regional Medical Center 112711003	Increase the ability to identify and treat patients with Gestational Diabetes and continue to manage their diabetes throughout pregnancy.	112711003.3.6- IT 1.10- Diabetes Care: HbA1c poor control (>9.0%)	$4,011,289
112711003.1.5: **ORMC Women's Clinic** Odessa Regional Medical Center 112711003	The Woman's Clinic will allow ORMC to tailor services and treatments to a specific population. This will be demonstrated through an increase in USPSTF endorsed screenings, including	112711003.3.7- IT 12.5 Other USPSTF endorsed screening outcome measure 112711003.3.8- IT 12.5 Other USPSTF endorsed screening outcome measure 112711003.3.9- IT 12.5 Other USPSTF endorsed screening outcome measure	$4,011,289
138364812.1.1: **Expand Specialty Care** Permian Basin	PBCC intends to increase Behavioral Health Care capacity, primarily psychiatric and	138364812.3.1- IT 6.1 Patient Satisfaction	$4,012,720

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**
Community Centers 138364812	counseling services, to patients who do not meet the Department of State Health Services (DSHS) definition of "Target Population".		
138364812.1.2: **Enhance Service Availability to Appropriate Levels of Behavioral Health Care** Permian Basin Community Centers 138364812	PBCC intends to increase the capacity of its detox and residential substance abuse facility from 22 to 42 beds. The goal of this project is to enhance access to intensive residential treatment and detoxification services, while reducing the need for local Emergency Departments (ED) in PBCC's catchment area to purchase expensive mental health and detox beds for crisis like situations that are substance abuse related. PBCC could treat these persons in a less restrictive environment.	138364812.3.2 IT 10.1- Quality of Life	$4,020,192
130725806.1.1: **Behavioral Health Telemedicine Expansion** West Texas Centers 130725806	West Texas Centers will expand access to behavioral health care through expansion of our current telemedicine network in Andrews, Howard, Reeves, Upton, Ward and Winkler Counties. All West Texas Center Counties in the RHP are served primarily via a current telemedicine system from the hub site of Big Spring, Texas. Acquisition of additional broadband capacity, hardware, software, office space, support staff and expansion of existing	130725806.3.1- IT 6.2 Other Improvement Target	$2,282,965

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**
	professional personnel contracts will provide increased access to care for consumers.		
Category 2: Program Innovation and Redesign			
135235306.2.1: **Comprehensive Heart Failure Management Program** Medical Center Health System 135235306	Create a new delivery system for outpatient heart failure management through a combination of navigation and innovative treatment methodologies.	135235306.3.5- IT 3.2- Congestive Heart Failure 30 Day Readmission Rate	$4,019,365
135235306.2.2: **MCHS-TTUHSC Care Transitions** Medical Center Health System 135235306	Create a Care Transitions program through collaboration with the Texas Tech School of Nursing that will ensure that patients are not only navigated through their admission, but in the outpatient realm as well.	135235306.3.6- IT 3.1- All Cause 30 Day Readmission Rate	$4,369,264
135235306.2.3: **MCHS Severe Sepsis Program** Medical Center Health System 135235306	Implementation of a Severe Sepsis program that will place heavy focus on internal and external education through the development of a Clinical Sepsis Coordinator position and Sepsis Surveillance Nurses.	135235306.3.7- IT 4.8- Sepsis Mortality	$1,766,791
135235306.2.4: **MCHS Mobility Teams** Medical Center Health System 135235306	Implementation of Mobility Teams throughout the hospital. These teams will be comprised of mainly volunteer nursing students who will help ensure that patients' are turned regularly to help prevent pressure ulcers.	135235306.3.8- IT 4.7- Hospital Acquired Deep Pressure Ulcers	$3,605,850
135235306.2.5: **Diabetes Outreach: Education and Screening** Medical Center Health System 135235306	Collaboration between MCHS and the Health Department to more actively screen for diabetes in the general population. Through the	135235306.3.9- IT 2.9- Uncontrolled Diabetes Admissions Rate	$4,644,543

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**
	development of 2 Diabetes Outreach Coordinators, we will be able to screen at multiple sites and expand educational opportunities to all types of patients.		
135235306.2.6: **MCHS Palliative Care** Medical Center Health System 135235306	Development of a palliative care program that will be focused on eliminating the stigmas associated with palliative care. This would include the development of a team that could assist physicians, caregivers, families, and patients through this difficult time.	135235306.3.10- IT 13.4- Proportion admitted to the ICU in the last 30 days of life	$4,337,454
135235306.2.7: **Faith Based Community Care** Medical Center Health System 135235306	Development of a Faith Based Community Care program that would create a liaison network that could help navigate patients through the complex health care world. These liaisons would be able to access MCHS's vast array of materials and would go through a rigorous training module.	135235306.3.11- IT 12.1- Breast Cancer Screening 135235306.3.12- IT 12.3- Colorectal Cancer Screening 135235306.3.13- IT 12.4- Pneumonia Vaccination Status for Older Adults	$3,701,461
136143806.2.1: **Establish/Expand a Patient Care Navigation Program: Decreasing Frequent Flyers in ED through EMS Patient Navigation Program** Midland Memorial Hospital 136143806	Over a third of Midland's EMS transports are for non-emergent reasons. We believe that by (1) developing and implementing a collaborative agreement between the 68NURSE program and EMS for telephonic triage services for non-emergent patients and by (2) collaborating with the local EMS to integrate an APRN on	136143806.3.6- IT-11.1 Improvement in Clinical Indicator in identified disparity group	$2,250,894

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**
	the EMS team, we can lower this rate by providing definitive care on site or by redirecting non-emergent patients to a more appropriate level of care. Non-emergent patients calling EMS for transport will receive services of 68NURSE to reduce non-emergent ED visits and provide onsite resources for appropriate level of care sites. We believe we could achieve as much as a 20% decrease in non-emergent EMS transports to the ED through on site APRN care or screening to a more appropriate level of care.		
136143806.2.2: **Expand Chronic Care Management Model – Tackling Community Diabetes** Midland Memorial Hospital 136143806	A combined effort of Midland Memorial Hospital, Midland Health Department and Midland Community Health Care Services Diabetes, our project seeks to increase screenings for diagnosis, HbA1c control and foot exams among the undiagnosed or inadequately treated diabetic patients in our region. Extrapolating data based on the CDC diabetes statistics, there are probably over 14,000 people with diabetes in Midland County, approximately 3,900 undiagnosed. The target population is adults with diabetes--either undiagnosed or untreated due to lack of	136143806.3.7- IT 1.10 Diabetes care: HbA1c poor control (>9.0%) 136143806.3.8- IT 1.13- Diabetes Care: Foot Care	$5,627,235

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 or cost barriers. By creating alternative venues for screening such as the MHD and neighborhood fairs, our goal is to reduce the number of undiagnosed and/or currently unsupervised cases in Midland County who seek costly, sporadic medical services in the ED or end up hospitalized.		
136143806.2.3: **Use of Palliative Care Programs: Integration of a Palliative Care Team into an Acute Care Hospital** Midland Memorial Hospital 136143806	The Palliative Care Team consult service will be a center of excellence in the practice of palliative care medicine by improving the quality of life of patients with serious, life-limiting illnesses and by providing ongoing education so providers at MMH can better understand the complex nature of life-limiting illnesses and increase their level of comfort dealing with end-of-life issues.	136143806.3.9- IT 13.1- Pain Assessment 136143806.3.10- IT 13.2- Treatment Preferences 136143806.3.11- IT 13.5- Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concern or documentation that the patient/caregiver did not want to discuss	$3,094,979
136143806.2.4: **Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population: Implement Evidence-based Health Promotion and Disease Prevention**	Increase public education of general health and wellness as well as disease prevention by sponsoring community events based on common health disorders or needs discovered from local ED and community clinic data located in neighborhoods of greatest need as identified by zip code. We will track this population to specific neighborhoods where	136143806.3.12- IT 11.1- Improvement in Clinical Indicator in identified disparity group	$3,376,341

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**
Programs Midland Memorial Hospital 136143806	community health events will be hosted to educate as well as offer free basic health screenings such as glucose, blood pressure and lipid profiles.		
081939301.2.1: **Diabetes Coordinated Care Center** Texas Tech University Health Science Center-Permian Basin 081939301	Our goal is to create a coordinated care center that will implement the core components of the chronic care model. The center will attend patients with diabetes and coordinate their care including all educational aspects of nutrition and self-management. The Diabetes Care Center at TTUHSC, which is accessible to all patients regardless of financial status, will be promoted in the community. Establishment of the DCC Center will enable us to implement a centralized, flexible, integrated, outpatient, coordinated diabetes care for all patients in all TTUHSC Family Medicine (FM) outpatient clinics in the Permian Basin thus reducing ED utilization by patients with the diagnosis of diabetes.	081939301.3.7- IT-1.11 Diabetes Care: BP Control (<140/80mm Hg)	$2,960,097
081939301.2.2: **New Model for Delivery of Diabetes Care in the Outpatient Clinic** Texas Tech University Health Science Center-	Our proposal focuses on the implementation of a new and transformed model for structuring the diabetes clinic visit, reaching out to the community with education	081939301.3.8- IT- 1.10 – Diabetes Care – HbA1C poor control	$2,125,198

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**
Permian Basin 081939301	initiatives on prevention or delay of diabetes, and on delivering comprehensive longitudinal care in a time-efficient, cost-contained format. The intent is to "raise the floor" on treating diabetic patients.		
081939301.2.3: **TTUHSC Continuity of Care** Texas Tech University Health Science Center-Permian Basin 081939301	This project will focus on strategies and logistics for capturing patients discharged from the hospital with the goal of providing referral and follow-up care resources to prevent readmissions. This proposal is based on the new US Government Commission statement of July, 2012 calling for public-private mechanisms to slow, prevent and delay the burgeoning epidemic of diabetes.	081939301.3.9- IT-3.3- Diabetes 30 day readmission rate	$1,442,099
081939301.2.4: **Identification and Intervention to address local gaps in Women's healthcare through education** Texas Tech University Health Science Center-Permian Basin 081939301	The project will address the challenges by producing a women's health education program, offering individual education with outpatient visits to increase compliance, patient ability to participate in care and improve patient community programs such as the ongoing collaborative effort between TTUHSC-PB Department of Obstetrics and Gynecology and the Ector County Independent School District. Case coordination will also be a part of the patient experience,	081939301.3.10- IT 12.1- Breast cancer screenings 081939301.3.11- IT 12.2- Cervical Cancer Screenings 081939301.3.12- IT 12.5- reduction in re reported STD's	$1,214,398

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**
	providing assistance with referrals for insurance coverage, referral to specialty care and provision of social assistance.		
176354201.2.1: **Establishment of a Primary Care Medical Home** Culberson Hospital 176354201	Development of a NCQA Medical Home to better meet the needs of Culberson County.	176354201.3.1- IT 9.2 ED Appropriate Utilization	$498,478
112711003.2.1: **ORMC Sepsis Program** Odessa Regional Medical Center 112711003	Implement both the resuscitation and management bundles through process improvement techniques in order to decrease the sepsis mortality rate.	112711003.3.10- IT 4.8 Sepsis Mortality	$4,011,289
112711003.2.2: **Congestive Heart Failure Clinic** Odessa Regional Medical Center 112711003	ORMC will develop a Congestive Heart Failure clinic to offer treatment and follow up services for patients presenting with this condition. The clinic will look at reducing readmissions for patients with this condition.	112711003.3.11- IT 3.2- Congestive Heart Failure 30 Day Readmission Rate	$3,259,172
112711003.2.3: **ORMC Chronic Care Management of Diabetes** Odessa Regional Medical Center 112711003	Develop and implement a diabetes program that consists of both an outpatient and inpatient program to support the regions diabetic population.	112711003.3.12- IT 1.10- Diabetes Care: HbA1c poor control (>9.0%)	$3,509,878
112711003.2.4: **ED Patient Care Navigation** Odessa Regional Medical Center 112711003	The patient navigator program will look at identifying and assisting a specific population to be identified within DY 2. The navigator program will help guide patients through various	112711003.3.13- IT 9.2- ED appropriate utilization	$3,509,878

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**
	healthcare options relating to their condition.		
136145310.2.1: **Expand Chronic Care Management: Diabetes** Martin County Hospital District 136145310	The goal of this project is to provide diabetic patients with, chronic conditions, proactive ongoing care that keeps the patient healthy and empowers them to self-manage their condition in order to avoid worsening health issues and the need for ER and/or inpatient care.	136145310.3.1- IT 2.9- Uncontrolled Diabetes Admission Rates	$1,416,595
09417602.2.1: **Diabetes Transition of Care** McCamey County Hospital District 09417602	Implement a pilot intervention for diabetic patients to improve HbA1C for those with uncontrolled diabetes, or newly diagnosed patients.	094172602.3.1- IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$48,000
138364812.2.1: **Integration of Behavioral and Primary Care** Permian Basin Community Centers 138364812	Permian Basin Community Centers (PBCC) intends to integrate primary care into the center's two largest behavioral health care clinics. These 2 clinics currently serve approximately 600 S individuals with SPMI. The goal is to have primary care physicians, case management, and support staff imbedded in PBCC's public mental health care clinics in order to provide a more cohesive continuum of care between behavioral health and primary care.	138364812.3.3- IT 10.1- Quality of Life	$8,723,286
112684904.2.1: **Implementation of a Certified Diabetes Education Program**	Implement a Certified Diabetes Education Program. The ultimate goal of the program is to develop and implement	112684904.3.1- IT 1.12- Diabetes Care Retinal Eye Exam 112684904.3.2- IT 1.13-	$969,833

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**
Reeves County Hospital District 112684904	chronic disease management interventions that are geared towards improving effective management of chronic conditions. This will have the ultimate effect of increasing the percentage of adult diabetes patients who have optimally managed modifiable risk factors with the intent of preventing or reducing future complications associated with poorly managed diabetes.	Diabetes Care Foot Exam 112684904.3.3- IT 1.14- Diabetes Care Microalbumin/Nephropathy	
112684904.2.2: **Mammography Program** Reeves County Hospital District 112684904	As a major part of the Reeves County Hospital District Cancer Prevention Program, the Hospital District will commence in a project to implement a mammography program in order to increase mammography screenings in the Hospital's geographic service area.	112684904.3.4- IT 12.1- Breast Cancer Screening 112684904.3.5- IT 12.2- Cervical Cancer Screening 112684904.3.6- IT 12.3- Colorectal Cancer Screening	$1,538,355
112684904.2.3: **Patient Experience Survey** Reeves County Hospital District 112684904	Reeves County Hospital District will commence in a project to improve the patient experience for all patients served by the Pecos Valley Rural Health Clinic through customer satisfaction surveys with the ultimate goal of increasing overall patient satisfaction.	112684904.3.7- IT 6.1- Patient Satisfaction	$836,063
130725806.2.1: **Behavioral Health and Primary Care Integration** West Texas Centers 130725806	West Texas Centers will develop a behavioral health and primary care integrated project in Howard County, Big Spring, Texas. Co-location will occur	130725806.3.2- IT 6.2 Other Outcome Improvement	$3,234,991

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**
	through a lease arrangement with Scenic Mountain Medical Center (SMMC).		

Section III. Community Needs Assessment

TABLE OF CONTENTS

DATA SUPPORTING INFRASTRUCTURE AND ACCESS DEVELOPMENT 1
Primary Service Area and Potential Patients 1
Population and Counties (Table A in Appendix supplements information) 1
Population Projections 2
Socioeconomic Profile of Residents (Tables B-D) 4
Health Professional Shortage Areas 4
Medically Underserved Areas 6
Supply of Physicians and Specialists (Tables H-M) 6
Healthcare Coverage (Tables N-P) 7
Disparities in Accessing Healthcare (Tables Q-S) 8
DATA SUPPORTING FOCUS ON HIGH BURDEN CONDITIONS: HEALTH FACTORS AND BEHAVIORS 9
Mental Health and Substance Abuse 9
Mortality (Table T) 10
Fertility and Natality (Table U) 10
Communicable Diseases (Table V) 12
Health Rankings 12
Health Factors (Table W) 12
Health Outcomes (Table X) 13
Counties in RHP 14 Ranked 14
Preventable Hospitalizations (Table Y) 14
SUMMARY: DEMAND AND NEED FOR SERVICES 16
DATA SOURCES 17

*LIST OF FIGURES AND TABLES**

Figure 1. Population Projections 3
Figure 2. Percentage of RHP 14 Rankings for Health Factors 15
Figure 3. Percentage of RHP 14 Rankings by Quartile 15

Table 1. Population Projections 2
Table 2. HPSAs and MUAs 6
Table 3. Pregnancy Rates, Ages 13 – 17 11
Table 4. Births to Mothers Less than 18 Years of Age 12

** further supporting data can be found in supporting data appendix*

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	*High rates of chronic disease, including cancer, diabetes, heart disease, cardiovascular disease, respiratory diseases, Alzheimer's, and obesity.*	*County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation* *Texas Department of Health and Human Services*
CN.2	*High costs associated with preventable hospitalization admissions and readmissions.*	*Texas Department of State Health Services, Center for Health Statistics*
CN.3	*Shortages of health care professionals, including primary care physicians and mental health care providers.*	*•Texas Center for Public Policy Priorities* *•Texas Department of State Health Services, Center for Health Statistics* *•Texas Medical Board* *•US Department of Health and Human Services, Health Resources and Services Administration*
CN.4	*Lack of primary care physicians specializing in gynecology or geriatrics.*	*Texas Medical Board*
CN.5	*Low utilization of preventative care services and screenings, especially by those with lower incomes.*	*Texas Behavioral Risk Factors Surveillance System*
CN.6	*Need to overcome patient access to care barriers. E.g., language, previous experiences, distant travel required for many residents to access cardiac, neonatal, and pediatric intensive care, screening sites, physical rehabilitation, and long-term care hospital services.*	*•Texas Behavioral Risk Factors Surveillance System* *•US Census Bureau*
CN.7	*Need for improvement in prenatal and perinatal care.*	*•County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation* *•Texas Department of Health and Human Services*
CN.8	*Shortages in dental care.*	*US Department of Health and Human Services, Health Resources and Services*

		Administration
CN.9	*Need for improvement in adolescent health, with focus on teen pregnancy, suicide, and obesity.*	*Texas Office of Adolescent Health*
CN.10	*Increase palliative care services.*	*Center to Advance Palliative Care and the National Palliative Care Research Center*
CN.11	*High rate of teen pregnancy.*	*Texas Department of State Health Services, Center for Health Statistics*

INTRODUCTION

A community needs assessment often focuses on barriers to accessing care. It can also describe the primary service area of a hospital, a hospital's patients and its services, other healthcare providers in the area, and demand for services. Assessments also aid in planning and improving access to and quality of care. This assessment concerns Regional Healthcare Partnership (RHP) 14 in Texas, which includes 16 counties: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, and Winkler. The assessment's purpose is to assist RHP 14 as it plans its proposal for the HHSC 1115 Waiver. The Delivery System Reform Incentive Pool (DSRIP) section of the waiver includes four categories:

Category 1: Infrastructure Development
Category 2: Program Innovation and Redesign
Category 3: Quality Improvements
Category 4: Population-focused Improvements

This assessment contributes supporting data for Categories 1 and 2. Providers in the respective region should contribute specific data to support the need for additional infrastructure, including clinic, emergency department, and inpatient hospital volume and cost data by payer and by condition. If infrastructure is determined to be required for particular disease areas, e.g., diabetes clinics, then provider-specific volume data should be provided as well. Categories 3 and 4 require data supporting high burden areas in particular, some of which are provided in this document, but again, should be strengthened with data from the region's providers. This assessment includes several supporting data tables and figures, most of which can be found in the Supporting Data appendix. Within the CNA, tables are numbered, while Appendix tables are ordered by letter and are noted in parentheses beside section subtitles.

DATA SUPPORTING INFRASTRUCTURE AND ACCESS DEVELOPMENT

A. Primary Service Area and Potential Patients

Population growth, age distribution, and race/ethnicity have a significant impact on community need for healthcare services. Overall population growth and growth by age cohort impact the total demand for healthcare services and demand for specific services,

while certain racial/ethnic backgrounds increase the likelihood of some diseases and disorders.

Population and Counties (Table A in Appendix supplements information)
Total population for RHP 14 grew by over 13% from 2000 to 2011. (See Table 1) All but two counties (Ector, Midland) in RHP 14 are considered rural by the 2010 U.S. Census. Population density per square mile for the region is 13.7. Ten counties (Brewster, Crane, Culberson, Glasscock, Jeff Davis, Loving, Martin, Presidio, Reeves, and Upton) in RHP 14 are considered Frontier Counties because they have less than seven people per square mile.

Almost 91% of RHP 14 residents identify as white, while 48% of all people, regardless of race, identify as Hispanic. Sixty-three percent speak English only. The region's percentage of the population 65 and older (11%) is about the same as Texas' percentage (10%).

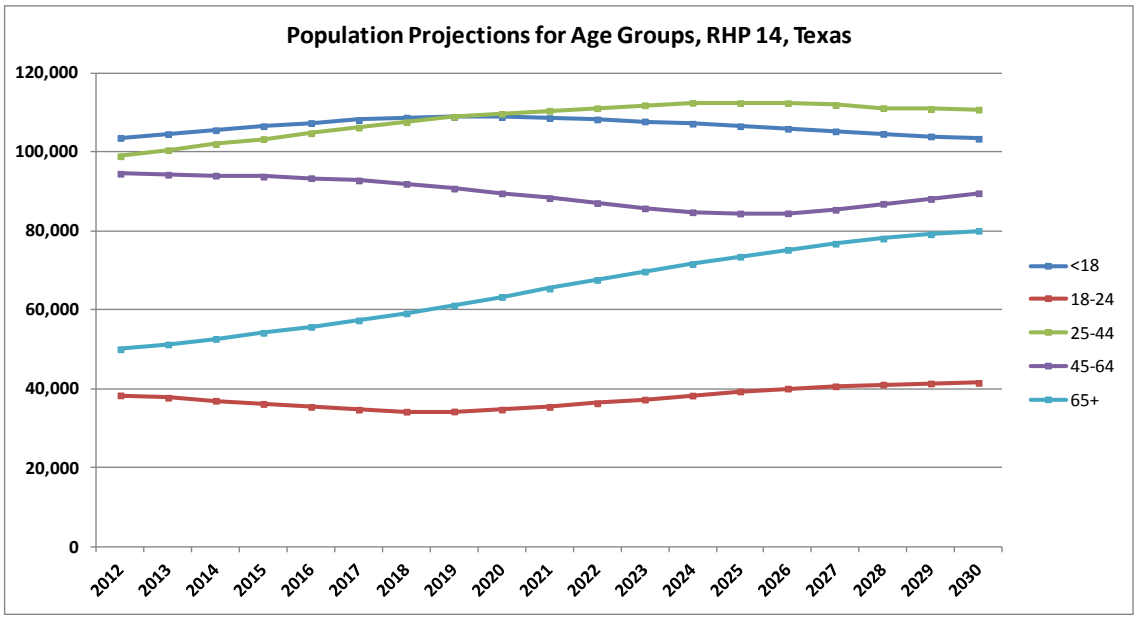
Population Projections
The Texas State Data Center and Office of the State Demographer estimated the population in 2012 to be 385,144. According to their estimates, the population will increase by 10% from 2012 to 2030, growing from 385,144 to 424,968. People aged 65 and older will account for a larger percentage of the population in 2030. (See Figure 1 below.)

Table 1. Population Projections

Population and Size, RHP 14, Texas	
Population	
2000	349,953
2010	390,978
2011	398,463
Population of RHP's counties (2011)	
Midland	140,308
Ector	140,111
Howard	35,122
Andrews	15,445
Reeves	13,757
Ward	10,716
Brewster	9,386
Presidio	7,761
Winkler	7,178
Martin	4,934
Crane	4,383
Upton	3,346
Culberson	2,383
Jeff Davis	2,288
Glasscock	1,251
Loving	94
Size in square miles	
Land area	29,138
Water area	37
Total area	29,175
Population density per square mile (2011)	13.7

Source: Census Bureau and Environmental Protection Agency

Figure 1. Population Projections



These population projections of growth are conservative as thousands are moving to this area given its recent oil boom.[1] Areas of RHP 14, e.g., Midland (Midland County), Odessa (Ector County), are currently some of the fastest growing cities in the nation.[2] The local economy is projected to expand by nearly 10% this year,[3] and Midland (4.1%) and Odessa (4.9%) report the lowest unemployment rates in Texas.[4] Businesses in these areas still desperately seek workers. Populations of some of RHP 14's small towns are also rapidly

[1] We used "One-Half 1990-2000 Migration (0.5) Scenario" from Office of the State Demographer. It assumes rates of net migration one-half of those of the 1990s. The reason for including this scenario is that many counties in the State are unlikely to continue to experience the overall levels of relative extensive growth of the 1990s. A scenario which projects rates of population growth that are approximately an average of the zero and the 1990 2000 scenarios is one that suggests slower than 1990-2000 but steady growth. However, the recent oil boom and population boom in this area suggest that the .5 population growth scenario is a conservative estimate.

[2] "100 leading locations for 2012," Area Development, 2012:55-73. Available: http://www.areadevelopment-digital.com/areadevelopment/201206#pg1. August 2012.

[3] Warbelow K. "Texas oil boom fueling trucker bonuses propels Odessa," Bloomberg. Available: http://www.bloomberg.com/news/2012-08-06/texas-oil-boom-fueling-trucker-bonuses-propels-odessa.html. August 2012.

[4] McEwen M. "Midland, Odessa report state's lowest unemployment," MyWestTexas.com. Available: http://www.mywesttexas.com/local_newsroom/article_18d407c9-e8aa-55a9-9a58-915843249afd.html. March 2012.

growing. Forbes named Pecos (Reeves County) and Andrews (Andrews County) as the second and ninth fastest growing small towns in America between 2007 and 2010.[5]

Socioeconomic Profile of Residents (Tables B-D)
Twenty-six percent of adults 25 years or older in RHP 14 did not graduate from high school. About 28% have some kind of college degree. Eighteen percent of all people in the RHP fall below the poverty line. The percentage of children living in poverty is 26%. The percentages of high school dropouts and poor people are expected to increase in Texas. According to demographer Dr. Steve Murdock, "The state's public schools have more and more low-income kids and persistently high dropout rates, and unless that changes, the future of Texas will contain more long-term unemployment and poverty, and more folks depending on food stamps, Medicaid and CHIP."[6] Median household income is lower than the median in Texas and the U.S. Per capita income in the RHP is similar to per capita income in Texas and the U.S. The average wage per job has increased since 2006. However, the unemployment rate has also increased over the last five years. (Table D in the appendix displays the major employers in RHP 14.)

Access to Healthcare (Tables E-G)
Rural Healthy People 2010, a companion document to *Healthy People 2010*, examined top rural health priorities and presented promising models to address *Healthy People 2010* objectives. Both public and private health organizations identified access to quality health services (primary care, emergency medical services, insurance, and long-term care) as the leading focus area. RHP 14 had nine hospitals in the Metropolitan Statistical Areas (MSAs) of Midland and Odessa and twelve hospitals outside the MSA as of 2011. Eleven of the hospitals are public, and ten are for-profit. There are 1,485 acute beds and 264 psychiatric beds among all of the region's hospitals.

As of 2009, none of the hospitals in RHP 14 had Teaching Facilities, Burn Care, Other Intensive Care, Alcoholism-Drug Abuse or Dependency Care, Skilled Nursing Care, Intermediate Nursing Care, Other Long Term Care, Other Care, Hospice Program, or Extra-corporeal Shock Wave Lithotripter. Big Bend Regional Medical Center, Culberson Hospital, McCamey County Hospital District, Permian Regional Medical Center, Reeves County Hospital District, Scenic Mountain Medical Center, and Ward Memorial Hospital have Medicare Defined Swing Bed Units.

Health Professional Shortage Areas
Texas ranks 42nd in the nation for the ratio of physicians to population, and 47th for the ratio of nurses to population. There is a shortage of every kind of health professional in Texas except Licensed Vocational Nurses. Physicians, registered nurses, physical therapists,

---

[5] Greenfield. "America's fastest-growing small towns," Forbes. Available: http://www.forbes.com/sites/bethgreenfield/2012/01/23/fastest-growing-small-towns/. January 2012.
[6] Scharrer, Gary. "Poverty, dropout rates threaten Texas' future," Austin Bureau. Available: http://www.chron.com/news/houston-texas/article/Report-Poverty-dropout-rates-threaten-Texas-1698327.php. June 2012.

clinical laboratory scientists, occupational therapists, pharmacists, dentists, audiologists, and other health care professionals all number less (per 100,000 population) than the national averages.[7]

The 2012-2013 Texas legislative budget allows for some growth in support for health-related institutions of higher education, but many programs sustained significant cuts. State support for Graduate Medical Education has been reduced by almost a third, from $79 million to $54 million. Funds for the Professional Nursing Shortage Reduction Program have been cut by 40%, and about three-fourths of funding for both the Family Practice Residency Program and the Physician Education Loan Repayment Program has been eliminated. Other primary care training programs have also been completely eliminated, including the Children's Medicaid Loan Repayment Program.

It is important for Texas to build its healthcare workforce in order to (1) reduce the current shortages and (2) prepare for large increases in demand when more Texans become insured in 2014 through the Affordable Care Act. Over $250 million in new federal medical education training funds have been allocated since the Affordable Care Act passed in 2010. The Texas legislature did not build on this investment in 2011, but instead made cuts to key health care professional training.[8]

Health Professional Shortage Areas (HPSAs) are designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental, or mental health providers and may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, federally qualified health center or other public facility). As of 2011, every county but three (Andrews, Loving, Upton) in RHP 14 is considered a Mental Health Professional Shortage Area. Ten counties are considered Primary Care Health Professional Shortage Areas. (See Table 2 below.) Five counties in the region have special populations with unmet needs. Special populations include: Medicaid eligibles, low-income populations, migrant and seasonal farm workers, homeless, American Indians, Alaska Natives, and other populations isolated by linguistic or cultural barriers. Six counties are designated as shortage areas for dental health professionals; four counties have facilities that treat special populations with limited access to dental care.

[7] Dunkelberg, Anne. 2011. Texas *Health Care 2011: What Has Happened and the Work that Remains*, Center for Public Policy Priorities. 2011. Available: http://www.cppp.org/files/2011_11_TexasHealthCare.pdf. June 2012.
[8] Ibid.

Table 2. HPSAs and MUAs

X" Denotes "Entire County" as Health Professional Shortage Area or Medically Underserved Area, RHP 14, Texas, September 2011				
	Primary Care	Mental	Dental	Medically Underserved Area
Andrews	Low-income	X		
Brewster	Low-income	X		X
Crane	X	X		X
Culberson	X	X	X	X
Ector	Facility	Facility	Facility	Partial
Glasscock	X	X	X	X
Howard	Low-income, facility	X	Facility	X
Jeff Davis	X	X	X	X
Loving	X	X	X	
Martin		X		Partial
Midland	Service area, facility	Low-income, facility	Facility	Partial
Presidio	X	X	Facility	X
Reeves	X	X	X	X
Upton	X	X		
Ward	X	X	X	X
Winkler	X	X		X

Sources: U.S. DHHS, Health Resources and Services Administration, Professional Shortage Areas, Designated on September 1, 2011. Texas DSHS. MUA and MUP Designations, Medically Underserved Area, 2010.

Medically Underserved Areas

Medically Underserved Areas designated by HRSA are those with too few primary care providers, high infant mortality, high poverty, or high elderly population. All but three counties (Andrews, Loving, and Upton) are designated as full or partial Medically Underserved Areas.

Supply of Physicians and Specialists (Tables H-M)

Medicaid funding has a large impact on the supply of physicians. For health professionals, Texas Medicaid fees fall well below commercial insurance or Medicare, and sometimes do not even cover the costs of services. The failure of Texas Medicaid rates to keep up with inflation—even before the recent rate cuts made by the legislature—discourages providers from agreeing to take Medicaid patients. For example, the Texas Medical Association's biennial poll of doctors shows the percentage of doctors taking on new Medicaid patients

has dropped steeply over the last decade.[9] The Hogg Foundation for Mental Health reports that less than one-third of Texas physicians accept Medicaid patients.[10]

Rate cuts during the 82nd Legislature were the largest healthcare budget cuts the Texas Legislature made since 2003—even larger than the CHIP cuts. Before the last rate increase in 2007, accumulated Texas Medicaid rate cutbacks had reduced physicians' fees to 1993 levels for most services. Due to these cuts, we expect the supply of physicians in the region to decrease relative to the population in the next five years.

"Direct Patient Care" (DPC) physicians are those who work directly with patients and do not include researchers, administrators, or teachers. For the region as a whole, the rate of DPCs per 100,000 population ranged from 129.3 in 2008 to 137.3 in 2011. Rates of DPCs in the state of Texas are higher than those of RHP 14. Midland County has the highest rate of Direct Patient Care physicians, while Winkler County has the lowest. "Primary Care" (PC) physicians are those who indicate that they have a primary specialty of General Practice, Family Practice/Medicine, Internal Medicine, Pediatrics, Obstetrics and/or Gynecology, or Geriatrics, and are a sub-set of DPC physicians. For the region as a whole, the rate of PC physicians per 100,000 people varied from 54.1 to 61.0 from 2008 to 2011. Rates of PC physicians in the state of Texas are slightly higher than those in RHP 14. Reeves County has the highest rate of PC physicians per 100,000 people, while Winkler County has the lowest.

Over the last five years, family medicine doctors have accounted for over one third of all primary care specialists. Percentages of each specialization have remained stable since 2008. According to the Texas Medical Board (2011), there are no primary care physicians in the region specializing in gynecology or geriatrics. The combined percentage of family medicine and family practice physicians in RHP 14 (41%) is higher compared to the state's combined percentage (35%).

Healthcare Coverage (Tables N-P)

About 40% of people living in RHP 14 have commercial insurance. Twenty-nine percent are uninsured, and the remainder relies on Medicare, Medicaid, or CHIP. People without healthcare coverage are less likely to have a usual source of care, to use preventive or specialty services, to obtain needed prescription medications, or to receive high-quality services. As a result, they are at increased risk of poor health outcomes and death. The latest data from the U.S. Census Bureau show that in 2010, Texas remained the state with the highest uninsured rate in the nation at 24.6%. The total number of uninsured Texans is 6.2 million—roughly 250,000 fewer than in 2009. Working-age adults saw a small increase in coverage through job-based insurance, which was a slight reverse in the long-term trend in loss of job-based coverage, made even worse by the recession. Despite the modest up-tick,

[9] Ibid.

[10] Martinez ON. Behavioral Health Panel: Addressing the Needs of Texas through Best Practices and Innovative Delivery Models. Presentation, Hogg Foundation for Mental Health. Available: http://www.hhsc.state.tx.us/1115-docs/August-7-8-Summit/7.1-Behavioral-Health-Panel-Martinez.pdf. August 2012.

Texas' working-age adults are still nearly twice as likely as children to be uninsured. Compared to Texas as a whole, RHP 14 has similar percentages of people who lack healthcare coverage. Compared to the U.S., the region and Texas have higher percentages of uninsured adults.

Medicaid is the foundation of Texas' health care safety net, providing health care benefits for over 3.3 million low-income Texans in September 2011. Children make up the greatest number of enrollees, but adults with disabilities, low-income seniors, pregnant women, and a small number of parents in poverty also rely on the program for critical medical care and community services and supports. About seven in 10 Texas nursing home residents rely on Medicaid for their care. Approximately 15% of RHP 14 residents are enrolled in Medicaid.

Disparities in Accessing Healthcare (Tables Q-S)

In recent decades, the U.S. has made much progress in improving health among its residents and in reducing health disparities, yet health disparities by race/ethnicity, income and education, geographic location, and other characteristics still exist. Public Health Administrative Region 9/10, which includes RHP 14 and the state of Texas have similar percentages of adults who could not access healthcare due to cost. RHP 14 and Texas have higher percentages than the U.S. In the region, the following groups were more likely than their counterparts to report that they could not access healthcare due to cost in the past 12 months: women, blacks and Hispanics, people younger than 65, those with no high school diploma, and people with low incomes. According to the Texas Behavioral Risk Factor Surveillance System (BRFSS), these groups were more likely than their counterparts to report that they were uninsured: Hispanics, younger adults, and those with no high school diploma, and those with income levels less than $25,000.

RHP 14 has a small population for its size and many people have to drive long distances for primary and specialty care (refer to Table 1). As previously stated, 10 of the 16 counties in RHP 14 are considered Frontier Counties because they have less than seven people per square mile. Nine of the region's twenty-one hospitals are located in the metropolitan areas of Midland and Odessa. Seventy percent of people in the region must travel to Midland and Odessa to access cardiac, neonatal, and pediatric intensive care, other special needs, physical rehabilitation, and acute long-term care in a hospital.

Screenings and the utilization of other preventative services are other access to care measures. RHP 19 has higher percentages of adults who did not access most of these specific aspects of preventative care than Texas and the U.S. The percentage of people 50 years and older who had a blood stool test was similar for the RHP, Texas, and the U.S. In the region, women aged 50 and older are less likely than their male counterparts to have had a blood stool test. Hispanic women are just as likely as white women to have had a mammogram or a pap smear. Those with lower levels of education and income are less likely than adults with higher education and income levels to receive most of these preventative services.

DATA SUPPORTING FOCUS ON HIGH BURDEN CONDITIONS: HEALTH FACTORS AND BEHAVIORS

Mental Health and Substance Abuse

In Texas, between 2001 and 2010, the number of psychiatric hospitals in Texas increased by 5% and the number of beds increased by 8%. Admissions for mental conditions increased by 22% across the State, indicating that the growth in services may not meet the growth in need.[11] Nearly 500,000 Texas adults have serious and persistent mental illness, with one in three receiving services from the community mental health system.[12] Less than half patients receiving referrals for specialty mental health services seek treatment from the referred specialists. As of 2009, Texas had less than seven psychiatrists and less than 70 social workers per 100,000 residents (ratios have fallen since 2000).[13]

In addition, of the almost 155,000 children diagnosed with severe emotional disturbances, only one-fourth are treated in the community mental health system. Suicide is the second leading cause of death in Texans 15 to 19 years of age.[14] The numbers of youth admitted to substance abuse treatment programs and have interacted with the criminal justice system increased in Texas from 4,305 in 2008 to 4,803 in 2011.[15]

Texas ranks 50th in per capita funding for mental health services.[16] Funding for community mental health services in the Texas Department of State Health Services budget escaped deep cuts in 2010-2011. However, no funding was provided to allow for inflation or population growth, so service levels per person will likely be reduced in some programs. For example,

- The number of children receiving community mental health services in 2012-2013 is projected to be the same as in 2011, though lower than in 2010. The 2012-2013 number represents a 6% gain over children served in 2003, though not enough to keep up with population growth.
- The number of adults receiving community mental health services has been flat since 2009 and remains at essentially the same number served in 2003. However, the population in Texas has grown by 3.3 million (15%), and the number of uninsured Texans has grown by nearly 1 million.

---

[11] Texas Hospitals: Utilization and Financial Trends. 2001-2010. Available: http://www.dshs.state.tx.us/chs/hosp/hosp5. July 2012.

[12] Martinez ON. Behavioral Health Panel: Addressing the Needs of Texas through Best Practices and Innovative Delivery Models. Presentation, Hogg Foundation for Mental Health. Available: http://www.hhsc.state.tx.us/1115-docs/August-7-8-Summit/7.1-Behavioral-Health-Panel-Martinez.pdf. August 2012.

[13] Ibid.

[14] Ibid.

[15] DSHS, Behavioral Health Data Book, FY 2012 Qtr 1, Jan 9, 2012. BHIPS and CMBHS.

[16] Martinez ON. Behavioral Health Panel: Addressing the Needs of Texas Through Best Practices and Innovative Delivery Models. Presentation, Hogg Foundation for Mental Health. Available: http://www.hhsc.state.tx.us/1115-docs/August-7-8-Summit/7.1-Behavioral-Health-Panel-Martinez.pdf. August 2012.

- The Legislature expressed intent to maintain state and community mental health hospital bed capacity, contingent on DSHS implementing $15 million in cost-containment policy changes in the state facilities.
- The number of adults and youth receiving substance abuse treatment is held at the 2010 level.[17]

Mortality (Table T)
RHP 14 has higher death rates than Texas for heart disease, chronic lower respiratory disease, accidents, Alzheimer's disease, motor vehicle accidents, influenza/pneumonia, cancers of colon, rectum, anus, and suicide.

Fertility and Natality (Table U)
Like every state, Texas funds family planning through both federal block grants and Medicaid coverage. These programs provide not only birth control, but also preventive care and basic check-ups to low-income and largely uninsured women (one-third of Texas' working age adults are uninsured). The 82nd Texas Legislature passed deep cuts in block-grant-funded family planning care that will reduce the total number of Texas women served with birth control by at least 70% in 2012-2013. The appropriations act for 2012-13 says that the Department of State Health Services (DSHS) Family Planning programs will serve 61,135 Texas women in each year of the budget; this is down from the actual 211,980 served in 2010—a 71% reduction (150,845 less) in clients served by DSHS programs. The Texas Legislative Budget Board estimated the 2010-2011 DSHS Family Planning spending at over $111 million, compared to appropriations for 2012-2013 of $37.9 million for the biennium. This results in a 66% reduction ($73.2 million) from 2010-2011—a two-thirds cut.[18]

Access is critical to reducing several Texas challenges: high and growing rates of pre-term births, births too close together causing medical risks for the newborn, and births to unmarried teen mothers. More than half of all Texas births are reported unplanned, and maintaining access to family planning services is essential to reducing unplanned pregnancies. Most of the fertility and natality-related rates are similar between the region and Texas.

Teen Pregnancy and Births
The Texas pregnancy rate per 1000 female teenagers between 13 and 17 years was 21.4 in 2010.[19] The overall rate in RHP 14 was higher (29.4/1000) than the Texas rate. Table 3 below displays the pregnancy rate among this population by county. Twelve of the 16 counties in RHP 14 have higher pregnancy rates among 13 to 17 year olds than Texas' overall rate. Reeves County had the highest rate at 50.7 per 1000, while Glasscock and Loving Counties had no reported pregnancies in this age group in 2010.

---

[17] DSHS, Behavioral Health Data Book, FY 2012 Qtr 1, Jan 9, 2012. BHIPS and CMBHS.
[18] Ibid.
[19] http://www.dshs.state.tx.us/chs/vstat/vs10/t14b.shtm

In 2010, 4.3% of births in Texas were to mothers less than 18 years of age.[20] The rate in RHP 14 (6.2%) was higher than in Texas. Table 4 below shows the percent of births to these young mothers by county. Ten of the 16 counties in RHP 14 have higher birth rates to young mothers than Texas' overall rate. Reeves County has the highest rate, while Glasscock and Loving Counties reported no births among this age group in 2010.

The birth rate to white, black, and Hispanic teen mothers in Texas was 1.8%, 5.0%, and 6.2%, respectively, in 2010.[21] Half of counties in RHP 14 showed higher rates in Hispanic mothers less than 18 years of age than overall Texas rates.

Table 3. Pregnancy Rates, Ages 13 – 17

Reported Pregnancy Rate Per 1000 Women Age 13-17 by County, RHP 14, 2010	
	Rate per 1000
Andrews	23.9
Brewster	23.3
Crane	14.7
Culberson	31.6
Ector	34.9
Glasscock	0.0
Howard	33.1
Jeff Davis	33.7
Loving	0.0
Martin	14.6
Midland	24.6
Presidio	35.5
Reeves	50.7
Upton	24.2
Ward	21.7
Winkler	17.0

[20] http://www.dshs.state.tx.us/chs/vstat/vs10/t11.shtm
[21] Ibid.

Table 4. Births to Mothers Less than 18 Years of Age

Births to Mothers ≤ 17 Years by County and Ethnicity, RHP 14, 2010				
	Total %	White %	Black %	Hispanic %
Andrews	5.2%	5.0%	0.0%	5.3%
Brewster	4.7%	3.4%	0.0%	5.9%
Crane	3.2%	0.0%	0.0%	4.7%
Culberson	10.7%	0.0%	0.0%	13.0%
Ector	6.8%	4.2%	4.1%	8.3%
Glasscock	0.0%	0.0%	0.0%	0.0%
Howard	7.0%	4.9%	n/a	9.3%
Jeff Davis	n/a	0.0%	0.0%	n/a
Loving	0.0%	0.0%	0.0%	0.0%
Martin	3.6%	0.0%	0.0%	6.8%
Midland	4.9%	2.4%	7.9%	6.9%
Presidio	8.9%	0.0%	0.0%	10.3%
Reeves	13.3%	0.0%	0.0%	15.4%
Upton	7.9%	4.8%	0.0%	n/a
Ward	6.6%	3.3%	n/a	9.5%
Winkler	3.9%	2.7%	0.0%	4.6%

Communicable Diseases (Table V)
The Varicella rate is much higher in RHP 14 than in Texas; the rate for AIDS is somewhat higher in the region.

Health Rankings
Health Factors (Table W)
There are many different variables that measure health behaviors and other factors related to health. We have chosen obesity, excessive drinking, motor vehicle crash death rate, Chlamydia rate, and teen birth rate for illustrative comparison. Obesity is a risk factor for adult-onset diabetes, coronary heart disease, and several other serious medical conditions that can lead to poor health and premature death. Chlamydia is the most common bacterial sexually transmitted infection (STI) in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death. RHP 14 has a lower excessive drinking rate than Texas and a higher teen birth rate than Texas.

Health Outcomes (Table X)
Among the many health outcomes, we include mother/baby issues of low birth weight and birth defects, and the chronic disease diabetes. In 2006, the leading causes of death in Texas

were 1) cardiac conditions, 2) cancer, 3) cerebrovascular diseases, 4) accidents, 5) chronic respiratory disease, and 6) diabetes. These rankings vary by race and ethnicity. However, as care for cardiac, cerebrovascular, and chronic respiratory conditions is largely covered by Medicare, we focus here on diabetes as a leading driver of costs in the Medicaid population. Other health conditions are worth exploring in future drill-down analyses with provider-specific data recommended at the Introduction of this assessment.

Low birth weight represents two factors: maternal exposure to health risks and an infant's current and future morbidity and premature mortality risk. Diabetes is one of the major causes of premature death in the U.S. and disproportionately affects some racial and ethnic populations. Among the Type I diabetic population in Texas, almost 19% of primary payment for hospitalizations in 2006 was provided by Medicaid, compared to 15% by Medicare. Among Type II diabetics, Medicaid was the primary payment source for 10% of discharges in 2008, compared to 43% by Medicare. The percentages of low birth weight babies and diabetes among adults are similar for the region and Texas. The region has a higher rate of premature death than Texas.

RHP 14 has identified a number of areas for improvement, including cardiovascular disease, diabetes, palliative care, prenatal and perinatal care, and adolescent health. As previously mentioned, **cardiovascular disease** is the number one cause of death in Texan. Nearly one-third of all deaths in 2005 were related to heart disease and stroke.[22] The state has identified two priorities regarding the improvement of cardiovascular care: (1) reduce the incidence of stroke in Texas and (2) prevent, treat, and control heart disease and heart attacks. RHP 14 has a higher rate of heart disease-related death than the state overall. Nearly 10% of Texas adults (1.8 million) in 2010 had been diagnosed with **diabetes**.[23] A total of 16.5% of African Americans in Texas, 11.0% of Hispanics, and 8.2% of whites have the disease, and prevalence has an inverse relationship with education level (14.4% in those with less than a high school education vs. 7.1% with a college education). Overall, Texas has improved in access to **palliative care** over the last few years with 42% of hospitals having palliative care programs in 2011 (up from 33% in 2008).[24] However, 43 states perform better on this measure. Proper **prenatal and perinatal care** is associated with successful fetal outcomes (e.g., live births, lower rates of preterm births and low birth weights). In RHP 14, 40% of pregnant women do not receive prenatal care in the first trimester of pregnancy and 9% of babies are born with low birth weights. The state of **adolescent health** in Texas is problematic. In 2008, Texas had the third highest teen birth rate (ages 15-19) in the nation,

---

[22] Texas Department of State Health Services. Texas Plan to Reduce Cardiovascular Disease and Stroke, 2008. Available: http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34551&id=34608&terms=heart+disease. August 2012.

[23] Texas Department of State Health Services. Texas Diabetes Prevention and Control Program: Diabetes Status in Texas, 2012. Available: http://www.dshs.state.tx.us/diabetes/tdcdata.shtm. August 2012.

[24] Morrison RS, Meier DE. America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals. Center to Advance Palliative Care and the National Palliative Care Research Center. Available: http://reportcard-live.capc.stackop.com/pdf/state-by-state-report-card.pdf. August 2011.

and ranked fourth for teen pregnancy rate.[25] High school students report that in the past 12 months, 14% have seriously considered suicide and 7% have attempted it one or more times. Texas obesity rates among adolescents are slightly higher than national averages (14% vs. 12%).

Counties in RHP 14 Ranked

The Population Health Institute at the University of Wisconsin produces *County Health Rankings* for almost all counties in the U.S. The *Rankings* are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. The Population Health Institute examined data for 223 Texas counties. Each received a rank from 1 to 223. Our Community Needs Assessment examined data for the counties in RHP 14. Using the percentile rank for each county, we determined the quartile in which the counties fell. Comparing the counties in RHP 14 to 223 Texas counties, the lower quartile (up to 24%) represents the *highest, or relatively better,* scores for health factors and outcomes. The upper quartile (75% to 100%) represents the *lowest, or relatively worse,* scores for factors and outcomes. Looking at the rankings for health factors, 53% of RHP 14 counties ranked relatively well in health behaviors; 47% ranked relatively poorly (Figures 2 and 3). Sixty-one percent scored relatively well for social and economic factors. There is great opportunity for improvement in clinical care, where about 69% of the counties were relatively worse off than other Texas counties. Thirty-one percent of RHP 14's counties ranked relatively well in mortality; 46% ranked relatively well in morbidity.

Preventable Hospitalizations (Table Y)

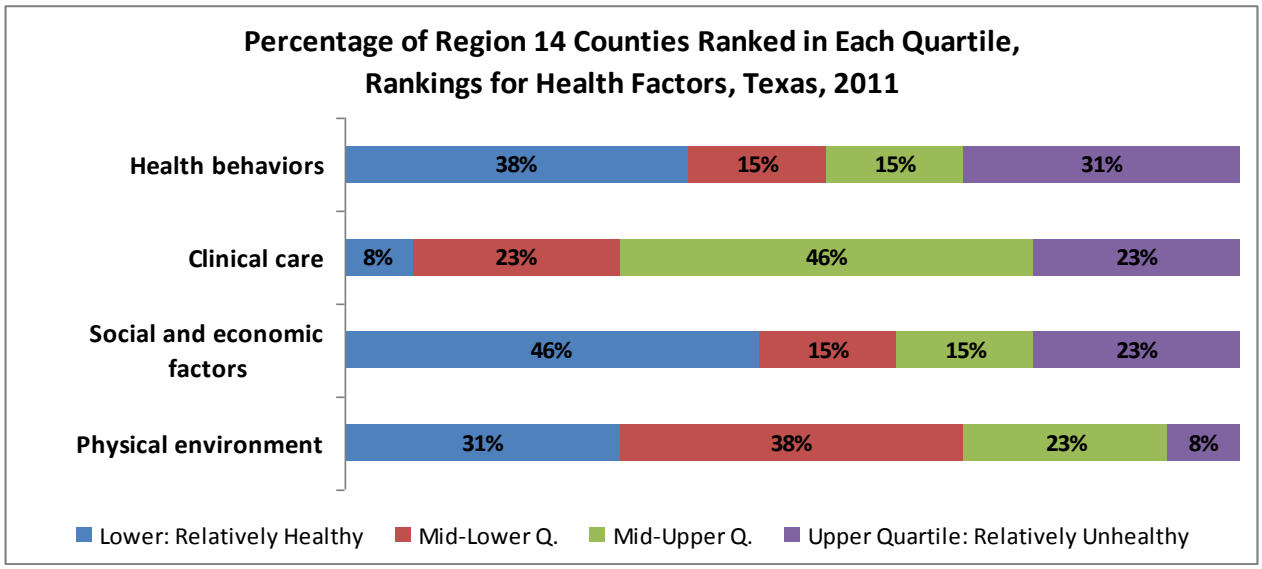
Hospital admissions increased across Texas by 8% between 2001 and 2010, and inpatient days increased by 7%. Also across Texas, emergency room visits increased by 29%, and inpatient surgical operations increased by 11%. Public Health Region 9, which covers 12 of RHP 14's 16 counties, has a similar hospital utilization rate (548 inpatient days per 1,000) than the state average of 546 inpatient days per 1,000 population.

In Public Health Region 9, bad debt charges totaled $16.1 million and charity charges totaled $3.1 million, for total uncompensated care charges of $34.6 million. As a percent of gross patient revenue, uncompensated care was 14.4% in PHR 9 in 2010, similar to the state's average of 14%.[26]

[25] Office of Adolescent Health. Facts About Adolescent Health in Texas. Available: http://www.hhs.gov/ash/oah/adolescent-health-topics/pdfs/tx.pdf. September 2012.

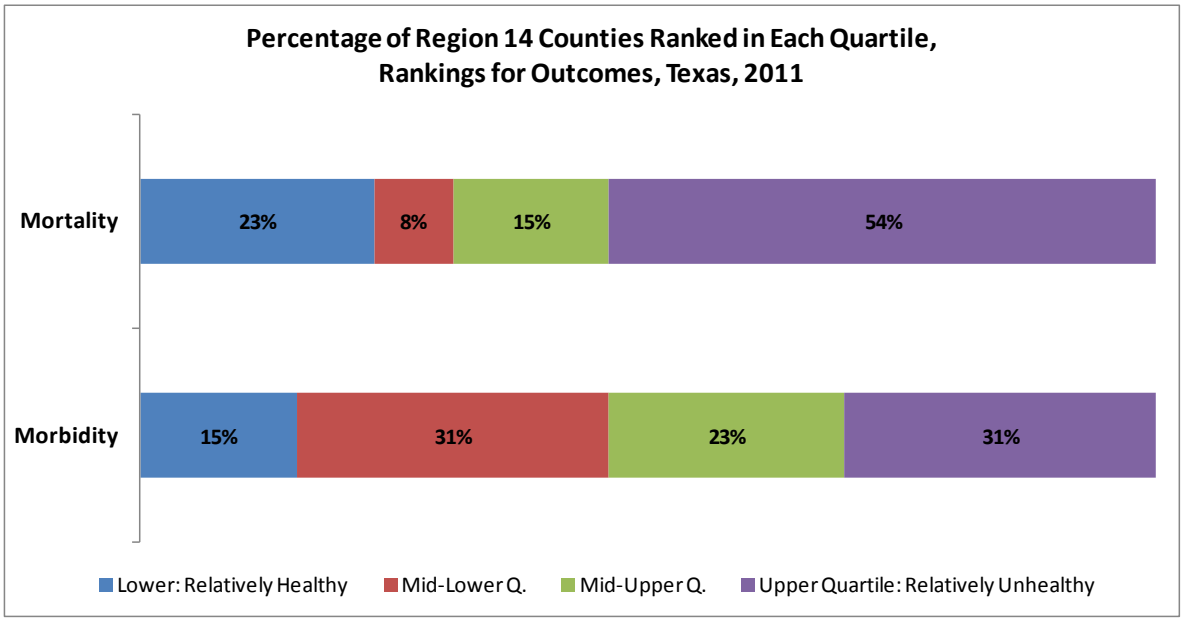
[26] Texas Hospitals: Utilization and Financial Trends. 2001-2010. Available: http://www.dshs.state.tx.us/chs/hosp/hosp5. July 2012.

Figure 2. Percentage of RHP 14 Rankings for Health Factors



Source: County Health Rankings, University of Wisconsin, Robert Wood Johnson Foundation

Figure 3. Percentage of RHP 14 Rankings by Quartile



Source: County Health Rankings, University of Wisconsin, Robert Wood Johnson Foundation

According to a recent analysis of THCIC data, RHP 14 received $461,193,683 between 2005 and 2010 for hospitalizations that may have been preventable. The two most costly hospitalizations per county resident were congestive heart failure ($115,444,073 per adult resident) and pneumonia ($99,814,350 per adult resident). These conditions in particular may be focus areas for quality improvement. Provider-specific data regarding volume and

other burden to the current healthcare infrastructure may be supplemented here to drive initiatives in these two high-burden conditions.

SUMMARY: DEMAND AND NEED FOR SERVICES

Regional Healthcare Partnership 14, compared to Texas as a whole, has similar percentages of White and Hispanics and people 65 years or older. RHP 14's percentage of older adults is expected to grow in the next 20 years, meaning that the expansion of services for chronic conditions related to coronary and cerebrovascular disease may be as cost-beneficial as those related to pre-natal and infant care, diabetes, and acute illnesses. Conditions of focus to reduce potentially avoidable hospitalizations, with both inpatient and outpatient efforts, may be congestive heart failure and bacterial pneumonia. These two conditions have the highest rate of reimbursement per county resident from 2005 to 2010.

The median household income of RHP 14 residents is lower than that of Texas and the U.S. Thirty-two percent of the RHP's adults are uninsured, and 19% of its children are uninsured. An analysis of ED overutilization may reveal an opportunity to shift ED visits among the poor to community based care. Additionally, with market reforms underway and expanded coverage in 2014 under the Affordable Care Act, the percentage of uninsured is expected to decrease.

The population of much of the region is inadequate to support full-time specialty physicians, so the community must rely on satellite clinics, telemedicine, and travel to secure specialty care. As of 2011, all but two counties in the region are considered full or partial Medically Underserved Areas. Medically Underserved Areas are areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty, or high elderly population. All but two of the counties in RHP 14 are designated as "whole county" Mental Health Professional Shortage Areas. The two have special populations designated as Mental Health Professional Shortage Areas. All of the counties are designated as "whole" or "partial" shortage areas for primary care health professionals. All but two are designated as "whole" or "partial" Dental Health Professional Shortage Areas. These shortages are expected to worsen in the short-term future.

Texas' health challenges have also been made more severe by a deep revenue shortfall from the global recession and the 82nd Texas Legislature's Budget for 2012-2013, which made deep cuts in health care investment. Cost-effective healthcare is a priority for RHP 14.

Prepared by Terri Conner, Ph.D.
Independent Healthcare Consultant

DATA SOURCES

This report presents the current data available from national, state, public, and private databases. Data are based on estimates, projections or self-reported information from different time periods. Data such as population and socioeconomic characteristics are not comparable among different sources. Please refer to the specific data source for complete description of methodologies:

- American Hospital Association Annual Survey of Hospitals 2009
- American Association of Medical Colleges
- Behavioral Risk Factor Surveillance System
- Bureau of Economic Analysis, U.S. Department of Commerce
- Center for Health Statistics, Texas Department of State Health Services
- County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation
- County Information Project, Texas Association of Counties
- eHealthScores.com
- Environmental Protection Agency
- Hogg Foundation for Mental Health
- Kids Count Data Center, Annie E. Casey Foundation
- National Center for Health Statistics
- Rural Policy Research Institute
- Texas Department of Health and Human Services
- Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center
- Texas Department of State Health Services, Texas Health Care Information Collection, Center for Health Statistics
- Texas Department of State Health Services, Texas Hospital List
- Texas Health and Human Services Commission
- Texas Medical Board
- Texas Population Estimates Program and Texas Population Projections Program, Texas State Data Center and Office of the State Demographer
- Texas Workforce Commission
- U.S. Census Bureau 2005-2009, 2009, 2010, 2011
- U.S. Department of Commerce, Bureau of Economic Analysis
- U.S. Department of Health and Human Services, Health Resources and Services Administration

Section IV. Stakeholder Engagement

A. RHP Participants Engagement

The engagement process started in some ways back in January of 2012. A few initial meetings were held with various stakeholders around the region to see what their initial thoughts were on the waiver and its implications. Formal letters were sent out to participants in May following the final map being decided upon. RHP 14 met frequently through a mix of WebEx and In-person meetings to allow for ample opportunities to ask questions and build plans. Over the course of the design phase, all communications from HHSC to the anchor were promptly forwarded to all participants and all participants were informed of any changes via e-mail on almost a daily basis. RHP 14 held meeting bi-monthly via WebEx or in person on the following dates:

RHP 14 Planning Meetings	*Executive Committee Meeting*	*RHP 14 Plan Presentation/Public Meetings*	*Planning Sessions with Consultant (Kevin Nolting)*
January 27th	*August 10th*	*May 22nd- Region 14 Public Meeting*	*July 16th-17th*
March 23rd	*September 7th*	*October 16th- PBCC Board Meeting*	*October 11th-12th*
May 18th	*September 21st*	*October 18th-Regional WebEx*	
June 15th	*October 5th*	*October 31st- Midland Memorial Public Board Meeting*	
June 29th	*October 24th-Plan Review*	*November 4th- Medical Center Public Board Meeting*	
July 13th			
August 7th-8th- Summit (10 Attendees)			
August 10th			
August 24th			
September 7th			
September 21st			
October 5th			
November 16th			
January 18th , 2013			

In July, RHP 14 decided to put together an Executive Committee to assist the anchor through the review process and to help facilitate the passes. Regional consensus dictated that the committee reflects all interested parties, so the following structure was decided upon:

EXECUTIVE COMMITTEE Structure	**Type of Organization**
Bill Webster, CEO- Medical Center Health System	8 Hospital Representatives- Mix Large Urban, Private, Rural

John O'Hearn- Anchor Contact- MCHS Russell Tippin, CEO- Permian Regional Medical Center Mike Metts, CFO-Odessa Regional Medical Center Russell Meyers, CEO- Midland Memorial Hospital John Irby, CFO- Scenic Mountain Medical Center Mike Ellis, CEO- Big Bend Regional Medical Center Lorenzo Serrano, Reeves County Hospital District	
Larry Carroll, CEO- Permian Basin Community Centers Keith Morehouse, CEO- BCA Odessa Shelley Smith, CEO- West Texas Centers	3 Behavioral Health Representatives
Gino Solla, Director- Ector County Health Department	1 Public Health Official
Kandy Stewart, Controller Texas Tech Health Sciences Center	1 Academic Medical Center Representative

RHP 14 was also an active participant on all HHSC webinars and presentations. John O'Hearn (Anchor contact) was present on all Anchor Calls.

RHP 14 will continue to meet quarterly starting in December 2012. We will also have Learning Collaboratives that will take place twice a year. Plans for the learning collaboratives will be put in place starting in December. RHP 14 will also be looking for additional funds at the beginning of DY3. Many providers already have plans in place that could be approved and executed in an expedited manner. MCHS as the anchor will collect plans over the course of DY2 in anticipation of funds becoming available.

B. *Public Engagement*

Public Meetings/Public Comment:

RHP 14's individual entities all worked diligently to let their communities know about the waiver and its implications. Public meetings were held throughout the region at different times and casual conversations regarding plans were very common during this entire process. RHP 14 held two public meetings over the course of the year to inform our local constituents about our work:

- May 22- A meeting was held in Odessa at Medical Center Health System to answer questions surrounding the program and what it meant to the region. A copy of that presentation is in the addendum.

- October 18th: A presentation was given by John O'Hearn via WebEx to the entire region. This presentation covered our process for selecting projects and gave a description of the final plan. Many of our performing providers held meetings to listen in and ask general questions.
- Our plan was posted online from November 21-28th for public comment on www.texasrhp14.com. Media and stakeholders were informed of the posting.

Individual performing providers also held public meetings to inform their boards and stakeholders of their plans and to elicit feedback on said plans. All public entities in RHP 14 presented their plans to their boards on a regular basis and used that feedback to edit their plans. Medical Center and Midland Memorial both invited members of the local press to their board meetings and articles were written (copies provided in the addendum).

Other Interested Stakeholders:

Numerous different public agencies and providers have been involved with RHP 14 during this process and will be involved moving forward. RHP 14 plans to publish all mid-year and end of year reports on our website to make sure that the public is aware of our progress in meeting the goals of the waiver projects. A few of those entities are:

- Ector County Independent School District
- BCA- Odessa
- Midland County Medical Society
- Texas Tech School of Nursing
- Ector County Medical Society
- StarCare Home Health

Section V. DSRIP Projects

A. RHP Plan Development

- RHP Tier level: Tier 4
- Minimum number of projects: 4 Total- 2 Category Projects
- Number of projects identified in Pass 1:
    - Category 1: 23
    - Category 2: 27
    - Describe the process used to implement Pass 1: For Region 14 the process was simple; projects were submitted to the executive committee and reviewed using the anchor checklist. Projects that required revisions were sent back to the provider to allow them to continue their work. This region includes numerous IGT entities, so their ability to participate and what they chose to do was really up to them. Our largest private hospital, ORMC, is being funded through Midland Memorial and therefore projects were vetted through the IGT provider.
- RHP 14 used an outside contractor to assemble the Community Needs Assessment, but the needs of the individual communities were communicated through the Anchor. These needs were identified at a local level by a group which included: Medical Staffs, Boards, and Community Focus Groups. After a few meetings and consultations with local stakeholders our Region's 2 primary needs became very apparent to all involved parties:
    1. **Expansion of Primary Care Services *(Physical and Behavioral)* -** Many of our counties are designated as Medically Underserved Areas (MUA) and therefore it became apparent that every performing provider would in some way focus on this issue. Projects include physician recruitment, clinic expansion, service line expansion, and increases in screening services. You will see a commitment to all types of primary care, including Pediatrics, Family Practice, Internal Medicine, and Obstetrics/Gynecology.
    2. **High Rates of Chronic Disease**- The rates of Congestive Heart Failure, Diabetes, and Asthma are alarmingly high in RHP 14 and it is essential that projects in this region work to find ways to curb that trend. Projects in the region range from the implementation of a Diabetes Education program to numerous projects focused on Congestive Heart Failure.

- Project selection in this region was very simplistic for the most part. The main reason for that is the makeup of our region. Almost every performing provider is their own OGT provider, therefore they have the ability to craft a plan that meets their community's needs as they see fit. Projects were vetted through individual boards and by the RHP 14 Executive Committee on October 24th. The majority of the projects met the needs as they were identified in the CNA. Moving forward, plans that are submitted over the course of DY2 for possible funding in DY3 will again be vetted by local stakeholders and

then by the executive committee. Projects that were not selected are listed in Addendum 10.

- Exempt from Category 4 reporting according to the criteria in paragraph 11.e. in the Program Funding and Mechanics Protocol:

Texas Tech University Health Science Center-Permian Basin	081939301
McCamey Hospital	094172602
Big Bend Regional Medical Center	094224503
Reeves County Hospital	112684904
Permian Regional Medical Center	127298103
West Texas Centers	130725806
Scenic Mountain Medical Center	131043506
Martin County Hospital District	136145310
Ward Memorial Hospital	136331910
Permian Basin Community Centers	138364812

B. Project Valuation

*****Many of the providers in are located in Frontier Counties as identified by DSHS and other entities, therefore funds were limited and doing more than one project would have been very difficult. This made their valuation relatively simple, but their projects were put through the same tests as larger entities with numerous projects.

Medical Providers in RHP 14 Methodology

The Medical providers in RHP 14 took a very simple 4 step approach to project valuation.

1. We decided as a region early on that we were going to build our plan around the IHI Triple Aim (Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care) and that any project that didn't meet some aspect of that was not going to be considered.
2. Once a project passed the IHI test, establishing a value was created by asking 4 simple questions:
    a. Does the project meet the waiver goals?
        i. This was crucial in our opinion to make sure that every project was created with the intention of meeting goals and metrics of the waiver. We wanted to avoid gray areas and make sure that HHSC and CMS's guidance was followed.
    b. Does the project address a pressing community need?
        i. Plans were put up against the community needs assessment to ensure that the project was actually meeting an unmet need in the community. We wanted to avoid simple service line expansion and vanity projects.
    c. Which population is being served?

i. The population in RHP 14 is very diverse and therefore our programs must be able to adapt to their changing needs. RHP 14 has a very high uninsured rate and a very large Medicaid population. Projects that were approved needed to show that these types of patients were being served.

d. What is the project investment (Resources needed)?

i. Given that many of our needs are unable to be addressed without a massive infrastructure upgrade, RHP 14 wanted to include this as a question in the process. Projects costs were taken into account as a final measuring stick, but it was definitely last on the list.

3. Once the questions were answered, providers ranked their projects in order of importance and then assigned the proper dollar amount.
4. All project valuations were discussed by the Executive Committee on October 24th and the same set of IHI and valuation questions were explored. All projects were deemed to be reasonable and have met the goals

Behavioral Health Providers Valuation Methodology:

There are 2 CMHCs in RHP 14 and they followed a methodology that was used across the state for valuing projects. The following valuation is based on work prepared by H. Shelton Brown, Ph.D., A. Hasanat Alamgir, Ph.D., UT Houston School of Public Health and Thomas Bohman, Ph.D., UT Austin Center for Social Work Research.

It uses the method of cost-utility analysis (a type of cost-effectiveness research), as well as additional information on potential future costs saved. See Attachment 4 in Addendum – Rationale for Economic Valuation.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature. Since integrated healthcare is synonymous with collaborative healthcare, the term “collaborative healthcare” will be used in this valuation to be consistent with the literature referenced.

C. Category 1: Infrastructure Development

Identifying Project and Provider Information:

Project Title: Eliminate Disparities in Health Care Access for the uninsured and underserved population of West Odessa (West Odessa Family Health Clinic)
Unique Category 1 Identifier: 135235306.1.1
***Performing Provider*:** Medical Center Health System TPI 135235306
***DSRIP Category*:** Category 1.1.1 Expand Primary Care Access

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will create a new primary care medical home for a vastly underserved population in West Odessa. The West Odessa Family Health Clinic will house Primary Care physicians specializing in Pediatrics, Family Practice, Internal Medicine, OB/GYN, and Optometry.
- Need for the project: We currently only have one clinic that serves as a FQHC Look-a-like. West Odessa does not have a primary care site and it is estimated that almost 30% of our population lives in that area.
- Target population: The target population is all Medicaid or uninsured patients living in the West Odessa area. Given the broad spectrum of coverage, almost all ages and acuities would fall under this clinic's structure.
- Category 1 or 2 expected patient benefits: The project seeks to provide primary care accessibility to thousands of underserved residents in Ector County. Many of these patients currently don't have a primary care medical home, so benefits will range from disease management to disease prevention. MCHS expects to conduct 3,700 Visits in DY 3, 8,000 visits in DY4, and 11,000 in DY5.
- Category 3 outcomes: IT-1.10 our goal is to reduce the % of patients presenting with a high HbA1c by 10% by the end of DY5.

Community health centers represent one of the nation's most prominent and enduring investments in the effort to build and sustain access to comprehensive primary health care for medically underserved communities and populations. Health centers play a particularly important role in the Medicaid program. Medicaid beneficiaries make up 39 percent of all health center patients and, nationwide, an estimated 14 percent of all Medicaid beneficiaries, or about one in every seven, receive care at health centers. Nearly a fifth (18 percent) of the primary care physicians who have a high share of Medicaid patients (defined as physicians who derive more than 25 percent of their practice revenues from Medicaid) work in health center settings. In many communities, health centers dominate the networks of Medicaid managed care plans; in 2010, 29 percent of health centers reported participating in capitated Medicaid

managed care arrangements, and 58 percent reported participating in some type of Medicaid managed care arrangement. Health centers make a major difference in access for the uninsured. Uninsured health center patients are more likely than similar patients nationally to report a generalist physician visit in the past year (82 percent versus 68 percent) and to have a regular source of care (96 percent versus 60 percent). Rural counties with a health center site have been shown to have a third fewer uninsured emergency department visits per 10,000 uninsured residents than rural counties without a health center site, as well as fewer emergency department visits that could have been avoided with timely primary care. The uninsured served in health centers experience better rates of recommended preventive care. Compared to uninsured women treated in other primary care settings, uninsured women served in health centers are 22 percent more likely to receive a Pap smear, 17 percent more likely to receive a breast exam, and 16 percent more likely to receive a mammogram. Controlling for age and race, gender, poverty level, and health related limitations, uninsured health center patients are 8 percent more likely to get cholesterol screening and 8 percent more likely to be screened for high blood pressure than uninsured patients in other primary care settings. The same pattern emerges from data on patients covered by Medicaid. America's health centers offer a proven solution to these complex problems. Health centers remove multiple barriers to primary care access and improve health outcomes, all in a cost-effective and locally-directed manner. Health centers are required to be open to all residents regardless of ability to pay or insurance status, target medically underserved areas, offer comprehensive primary care services, and be directed by a local patient-majority governing board. Countless studies document that health centers reduce or eliminate barriers to care, improve health, and lower health system costs. As barriers to primary care continue to threaten the health and productivity of our nation, health centers stand ready and willing to expand and break down these barriers. The dedicated stream of mandatory funding for health centers enacted under the Affordable Care Act is a promising starting point for continued expansion. Building the nation's primary care system on a strong foundation of health centers is only attainable, however, with sufficient investment to support expansion efforts and to maintain existing operations.

The goals of the proposed project are: (1) Provide a facility that can accommodate and support growth in primary medical and specialty care along with enhanced community and patient health education and counseling; (2) Support community efforts to redevelop and revitalize the area of West Odessa. The proposed facility will allow MCH to expand and improve services to the service area's population in four critical ways: First, the new facility will provide 20 additional exam rooms to accommodate the addition of one family physician, one OB/GYN, one FTE APN, one Endocrinologist and one Ophthalmologist. This increased staff is expected to enable the clinic to serve 2500 new patients and provide an additional 8000 encounters annually. Second, the additional space is essential if MCH is to fully utilize the capacity of its electronic health record and clinic management software system. The full utilization of the electronic systems will reduce staff recordkeeping time and operating costs while simultaneously improving patient monitoring and care. Third, improved linkage and access to secondary and tertiary care providers at Texas Tech. Fourth, the expanded space will allow MCH to expand its provision of community and patient health promotion, education and counseling services. These services, such as self-management classes for patients with diabetes,

smoking cessation, and nutrition counseling for the overweight are vital tools in addressing the long-term health needs of our residents.

Relationship to Regional Goals:

- RHP 14 has been focused on expanding care through the development of primary care access points in underserved areas. This project will place a clinic in an underserved area of Odessa, thereby providing access to insured and uninsured alike.

5 Year Goals:

- Build West Odessa Family Health Clinic
- Establish clinic as West Odessa's Medical Home for Pediatric, Family Practice, Obstetrics, and Optometry.
- Work in conjunction with Healthy Kids Program, Faith Based Community Care, Diabetes Center and Outreach Program, and the Care Transitions program.
- Reduce Poor HbA1C control by 10% at the end of DY5

Challenges/Issues

- Barriers to Care—such as affordability, availability, and accessibility;
- Poor Health Outcomes—often due to a lack of preventive screenings; and
- Economic Consequences—due to using the Emergency Department and hospital rather than primary care

Starting Point/Baseline Data (if applicable)

In our first year of operations (DY3), we expect to around 3700 visits given the mid-year opening. Based on that data, we project an increase to 8000 visits in DY4 and an increase to 11000 patient visits in DY5.

Rationale:

- **This project meets CN1, CN3, and CN 5 that were identified in the Community Needs Assessment.**

In Ector County, 29% of the population is uninsured. There are over 19,000 Medicaid enrollees in Ector County alone. According to recent studies, 30% of elementary age students live west of Loop 338, which means this clinic will be perfectly positioned to meet the needs of the community. There is a huge need to meet the demands of this growing population. Our struggles remain in recruiting physicians to provide primary care to all of these patients. Many physician offices are not seeing the Medicaid and Uninsured patient population, but being a Federal Qualified Health Center Look Alike, we are required to see these patients. Because we are a Look Alike designation, we do not receive federal funding for treating this population, but are required to serve them regardless of their ability to pay. Because of MCH's commitment to the mission of Family Health Clinic and the FQHC LAL status, these patients are being served according to these regulations.

Continuous access to primary care is critical to rein in health care costs and prevent the health care system from becoming overloaded and misused. Numerous studies have documented the savings that result from using primary care as opposed to tertiary levels of care. In addition to providing comprehensive services in West Odessa, the health center also will provide supportive services, such as transportation, interpreters, case management, and health education that increase access in the West Odessa area. To cater to their large elderly population, the health center also assists to provide nursing home placement and home visiting services. These health center services hope to have:

- 25% fewer uninsured Emergency Department visits for ambulatory care sensitive conditions compared to rural counties without a health center,
- $5 billion annually returned to rural communities through employment and supplier purchases
- Increased rates of pap smears among rural health center female patients compared to rural women nationally
- Lower rates of low birth weight among rural health center patients than among patients of other providers.

Related Category 3 Outcome Measure(s):

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)* [27] *- NQF 0059 (Standalone measure)*

Key Factor Description:

The West Clinic will work with the Diabetes Center for diabetic education, including nutrition, exercise, medication management and blood glucose testing. Also having an Endocrinologist work out of the clinic two days a week will allow access for focus treatment on diabetes.

Major Planned Action Description:

Increase number of referrals to Diabetes Center and work with Diabetes Center in offering satellite classes at clinic on site. Have focused classes with the endocrinologist by offering group class sessions.

Relationship to other Projects

The health center will work closely with the Care Transition Program to assist with creating open access slots so those patients can be seen by a physician. The Case managers and community navigators will assist to direct patients to the clinic to help prevent avoidable Emergency Department visits. The clinic will allow more of collaboration for chronic disease patients to assist in better health outcomes for the community.

Relationship to Other Performing Providers' Projects in the RHP:

No direct correlation outside of Ector County

---

[27] http://www.htsrec.com/janda/pdf/2012EP_MeasureSpecifications/NQF%200059/NQF_HQMF_HumanReadable_0059.pdf

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

- Readmission data suggest that $216 million in charges could have been avoided with proper outpatient management 10,669 Hospitalizations

- Diabetes alone accounted for 1356 avoidable hospitalizations and over $30 million dollars in charges

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, this project was deemed to be our most pressing project and therefore was given the highest allocation.

135235306.1.1	***1.1: Expand Primary Care Access***	***1.1.1 Establish more primary care clinics***	***Eliminate Disparities in Health Care Access for the uninsured and underserved population of West Odessa- West Odessa Family Health Clinic***
Performing Provider Medical Center Health System		***TPI 135235306***	
Related Category 3 Outcome Measure(s):	*135235306.3.1*	*IT 1.10*	*Diabetes Care: HbA1c Poor 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-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign Metric 1 [P-X.1]: Submission of planning process documentation Data Source: Planning documents Milestone 1 Estimated Incentive Payment (maximum amount): $2,128,148	Milestone 2: [P-1]: Establish additional primary care clinics Metric 1:[P-1.1]: Establish West Odessa Family Health Clinic Data Source: Planning and construction documentation Milestone 2 Estimated Incentive Payment (maximum amount): $773,898 Milestone 3 [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers Baseline/Goal: Addition of Family Medicine, OB/GYN, Pediatrics and Ophthalmology. Data Source: Contract	Milestone 5 [I-15]: Increase access to primary care capacity. Metric 1: [I-15.2]: Increased number of primary care visits. Goal: 8,000 Patients Visits Data Source: EHR Milestone 5 Estimated Incentive Payment (maximum amount): $2,328,444	Milestone 6 [I-15]: Increase access to primary care capacity. Metric 1: [I-15.2]: Increased number of primary care visits. Goal: 11,000 Patients Visits Data Source: EHR Milestone 6 Estimated Incentive Payment (maximum amount): $1,923,497

	documentation Milestone 3 Estimated Incentive Payment (maximum amount): $773,898 Milestone 4 [I-15]: Increase access to primary care capacity. Metric 1: [I-15.2]: Increased number of primary care visits. Goal: 3,700 Patients Visits Data Source: EHR Milestone 4 Estimated Incentive Payment (maximum amount): $773,898		
Year 2 Estimated Milestone Bundle Amount: $2,128,148	Year 3 Estimated Milestone Bundle Amount: $2,321,694	Year 4 Estimated Milestone Bundle Amount: $2,328,444	Year 5 Estimated Milestone Bundle Amount: $1,923,497
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $ 8,701,783			

Identifying Project and Provider Information:
Project Title: MCHS Healthy Kids Program
Unique Category 1 Identifier: 135235306.1.2
Project Category: 1.1.1 Expand Primary Care Access
Performing Provider: Medical Center Health System TPI: 135235306

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will implement a new pediatric health program called the "MCHS Healthy Kids Program". In addition to providing new primary care access points, MCHS will also look to partner with local entities to establish programs that focus on health literacy and common childhood afflictions. We will be looking into obesity programs and programs that look at asthma exacerbations.
- Need for the project: Pediatric Care in Ector County is limited and disjointed. Many residents are unable to find a primary pediatrician for their child and programs to combat diabetes and obesity are limited. This project will provide much needed access to primary services and help coordinate local entities to better serve Ector County's children.
- Target population: The target population is children and adolescents, especially those with Medicaid in Ector County. MCHS is working towards ensuring that every child in Ector County has a primary pediatrician. Through the health literacy aspect of this project, we hope to develop programs aimed at obesity and diabetes. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to provide primary care benefits to underserved Ector County children. Given our current population increase, exact numbers of children lacking a primary pediatrician are difficult to ascertain, but it is believed to be upwards of 30% according to different entities. MCHS expects 540 visits in DY 3, 4460 visits in DY4, and 6690 visits in DY5. In DY3 we are expecting a mid-year opening so volume will be hindered due to short timeframe.
- Category 3 outcomes: IT-3.11 MCHS's goal is to reduce the 30-day potentially preventable pediatric asthma readmission rate from by 15% by DY5.

Ector County has a long history of having very sporadic pediatric coverage in the community. While there has been a steady stream of private pediatricians in the area, their ability to provide services to the ever-growing population in Ector County is not there. According the Texas Medical Board in 2011 there were only 3 licensed pediatricians in Ector

County. This number has risen since that time but not at the same rate as population growth. In order to provide more access to care, MCHS has developed the Healthy Kids Program. The Healthy Kids Program will consist of three main components:

1. Providing more access to primary care through the opening of a Healthy Kids Clinic in Odessa, TX. This full-service pediatric clinic would feature 2-3 pediatricians and 1 Nurse Practioner that would run the clinic on a day-to-day basis and would provide after-hours express care for the children of Ector County.

2. Providing more access to specialty care by establishing a rotating suite for pediatric specialists in the same space. MCHS will work in DY2 to establish a partner for that clinic.

3. This program will work with to establish open lines of communication with the school nurses and the families in ECISD. During our planning year, the primary focus will revolve around finding the gaps in our referral patterns and in our health education.

Relationship to Regional Goals:

RHP 14 has been focused on expanding care through the development of primary care access points for children and young adults. This project will place a clinic in a heavily populated area and will provide needed pediatric services, both primary and specialty.

5 Year Goals:

1. Establish Healthy Kids Clinic
2. Increase overall clinic volume year over year
3. Ensure that Healthy Kids Program becomes the community leader in Pediatric Care.
4. Decrease Pediatric Asthma 30-Day Readmissions by 10%

Challenges/Issues:

1. Finding Physicians
2. Establishing Databases that can successfully track patients
3. Will this, when coupled with the West Odessa Family Health Clinic have the ability to provide enough PC Providers and space to keep pace with the population surge we are experiencing.

Starting Point/Baseline Data (if applicable)

Baseline data for visits will be attained during DY3. ER Visits for Pediatric Asthma will also be attained during DY3

Rationale:

As of 2011, Ector County was designated as a partial Medically Underserved Area. This number doesn't take into account our rapid population growth over the past year which would

presumably push that underserved number even higher. According to the Ector County Independent School District, 30% of their elementary age students do not have a pediatric home listed and that when combined with the following data further stresses the need for this project:

- Total Children Under Age 19 Enrolled in Medicaid: 16,600
- Total Enrollment in Children's Medicaid: 15,902
- A total of 28% of children live in poverty.
- 39% of Ector County Children live in Single Parent homes
- 20,071 children with limited access to healthy foods
- Ector County ranked 191 out of 221 counties in terms of health outcomes and 200 out of 221 in health factors.

Related Category 3 Outcome Measure(s):

IT-3.11 Pediatric Asthma 30-Day readmission rate

We chose this measure to make sure that we focus on one specific disease state during the course of the waiver. Asthma rates in Ector County continue to climb and it accounted for 276 ED visits and 222 Inpatient Admissions in 2011.

Relationship to other Projects

Direct correlation to one project- This project will be based around a pediatric primary care team that will include doctors and mid-levels from:

1. Eliminate Disparities in Health Care Access for the uninsured and underserved population of West Odessa- the Healthy Kids Program will work with the newly established West Odessa Family Health Clinic and the Family Health Clinic to establish pediatric outreach programs focused around proper health and wellness.

Relationship to Other Performing Providers' Projects in the RHP:

No direct correlation

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?

2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Healthy Kids Program was deemed to be our 2nd most pressing project and therefore was given the 2nd highest allocation.

135235306.1.2	***1.1***	***1.1.1 Expand Primary Care Capacity***	***MCHS Healthy Kids Program***
Performing Provider ***Medical Center Health System***		***TPI*** ***135235306***	
Related Category 3 Outcome Measure(s):	***135235306.3.2***	***IT- 3.11***	***Pediatric Asthma 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-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign Metric 1: [P-X.1]: Conduct research on outpatient outreach protocols, clinic space needed, and staffing plan. Submit Plan Goal: Complete Plan, start on needed clinic space Data Source: Completed Plan Milestone 1 Estimated Incentive Payment (maximum amount): $2,117,592	Milestone 2 [P-1]: Establish pediatric primary care clinic Metric 1 [P-1.1]: 1 additional clinic Goal: Open Clinic, implement program Data Source: Completion documents Milestone 2 Estimated Incentive Payment (maximum amount): $1,155,090 Milestone 3 [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Data Source: Documentation of	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 Goal: 4,460 Patients Visits Data Source: EHR Milestone 4 Estimated Incentive Payment (maximum amount): $1,158,448 Milestone 5 [I-13]: Enhanced capacity to provide urgent care services in the primary care setting. Metric 1: [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request.	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 Goal: 6,690 Patients Visits Data Source: EHR Milestone 6 Estimated Incentive Payment (maximum amount): $956,979 Milestone 7 [I-13]: Enhanced capacity to provide urgent care services in the primary care setting. Metric 1: [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of

	completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation Milestone 3 Estimated Incentive Payment (maximum amount): $1,155,089	Goal: Demonstrate 10% improvement over baseline rates Data Source: EHR Milestone 5 Estimated Incentive Payment (maximum amount): $1,158,447	request. Goal: Demonstrate 20% improvement over baseline rates Data Source: EHR Milestone 7 Estimated Incentive Payment (maximum amount):$956,978
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $2,117,592	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $2,310,179	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $2,316,895	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,913,957
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $8,658,623			

Identifying Project and Provider Information:
Expansion of Women's Health Services Access in Ector County
Unique Category 1 Identifier: 135235306.1.3
Project Option: 1.1.1- Expand Primary Care Access
Performing Provider: Medical Center Health System TPI: 135235306

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will implement a new Women's Initiative for MCHS by implementing a new OB/GYN group that will cover an on-site clinic and cover the Family Health Clinics as well. Health literacy will play a key role in this initiative. We will also attempt to implement a program focused on centering concepts at both Family Health Clinic sites.
- Need for the project: Ector County has a very high teen pregnancy rate and an exploding population. Recent population statistics put our average female resident at 30 years old. All facilities in the area are seeing record delivery numbers, but data is still showing that 13% of pregnant moms in Ector County receive no prenatal care. In addition, Thomson Reuters estimates that Odessa will need 10 OB/GYNs over the next ten years to keep up with demand and population growth. By establishing a group that can provide coverage across different care sites, we can ensure that all patients are getting consistent care.
- Target population: The target population is all women of child-bearing age, but more specifically Medicaid and uninsured patients. Our goal is to drastically reduce the amount of women not receiving prenatal care in Ector County. By changing the care model and offering a different type of visit we hope to create a more caring environment for mothers lack an adequate support system. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to provide a medical home for patients over the next 4 years. DY 2 is dedicated to planning and clinic expansion, so baselines won't be available until after DY3, but our goal is to increase visits by 15% over established baseline by DY5. MCHS expects to see 2,676 visits in DY 3, 4,460 visits in DY4, and 8,920 in DY5.
- Category 3 outcomes: IT-8.3 (Early Elective Delivery) our goal is to reduce the number of early elective deliveries by a TBD% by DY5. We feel that through proper prenatal care and patient follow-up we can positively affect this number.

In Ector County, we have an exploding population due to the recent upswing in oil and gas production. This has led to a large influx of new residents with many of those being of child bearing age. Many of these new residents are already collecting Medicaid or in many cases are uninsured, which puts them at risk of not having proper prenatal care due to the lack of access to an OB/GYN. According to a study conducted by Thomson Reuters in 2011, Ector County is going to require 9.6 additional OB/GYNs in the next ten years (Thomson Reuters, 2011). Another aspect of our county profile highlights the need for more access points are our teen pregnancy rates, which are some of the highest in the state. Our plan would revolve around the establishment of a new hospital based general OB/GYN group located on the MCHS campus that would serve all patient types, but would have a specific focus on providing access for the Medicaid population. This group would be closely aligned with our local medical school, Texas Tech Health Sciences Center, which would provide excellent opportunities to collaborate on community initiatives. This group would also staff the existing FQHC look alike as well as the one we have planned in this waiver. The ability for the group to expand throughout the community will allow for greater collaboration between the clinics and will increase their ability to provide consistent care in vastly different settings. We will also be exploring the need to expand our women's service line to include specialties in urogynecology and oncology.

Projects specifics:

- **Renovate existing space on MCHS campus for Primary Clinic**
- **Hire 3 to 4 General OB/GYNs to staff clinic and hire staff. Two to Four NRP/Midwives to be located at Family Health Clinic and Family Health Clinic-West Odessa to provide access for low-income and Medicaid patients. This would be done in collaboration with the Texas Tech Health Sciences Center to ensure that effective clinical practices were observed by students and residents in order to better prepare them for upcoming changes to the care model.**
- **Write plan to alter care model in practice, built around centering concepts (especially in Low-income population). Using a model implemented by University Health System in San Antonio as a best practice.**

MCHS's goal is to increase our ability to provide high quality, compassionate OB/GYN consultations to all residents in Ector County. The ability to remove barriers to care by providing more access would have the capability to reduce unnecessary Neonatal Intensive Care visits and greatly increase the amount of prenatal care many of these mothers could receive. Our milestones will be built around increasing overall patient volume from an initial starting baseline that will be set in year 3 and increasing patient visits by 10% and 15% respectively over initial baseline in years 4 and 5. A focus on perinatal outcomes will be coordinated through the MCHS Center for Women and Infants and strict adherence to the March of Dimes 39 week initiative and the Texas Ten Step Program will help us in this endeavor. Implementing the new model of care, focusing on increasing access to support groups and group collaboration will also

be included as milestones within this project. For years two and 3 our milestones will revolve around infrastructure development (i.e. Construction, staffing) and care plan development.

Centering is not a new concept, but it has shown tremendous results when implemented properly. Outcomes for people getting care in group are uniformly better than for those in traditional care. In a randomized control trial conducted through Yale University on 1047 women in public clinics randomized to traditional or group care there was a 33% reduction in preterm birth for women in centering groups. In addition, satisfaction with care was significantly higher, there were increased breast feeding rates, and improved knowledge and readiness for birth and parenting.

Relationship to Regional Goals:

A common theme throughout RHP 14 is our abnormal rates when it comes to certain pregnancy related data points. Our teen pregnancy rate is higher than the Texas average and we have a high percentage of women who don't receive any type of prenatal care. This project focuses on expanding access at the main access points and works on implementing innovative to create a stronger OB/GYN program in Ector County and therefore the region.

Starting Point/Baseline Data (if applicable)

Baseline Data will be determined during Demonstration year 3. During that year we will establish patient volumes and the % of early elective deliveries.

Rationale:

This project meets Community Need 7 and 9 from the Community Needs Assessment.

In Ector County and overall in RHP 14 we have a large need for primary care physicians as highlighted by the Thomson Reuters gap analysis. We have an aging physician population and a general population that continues to get younger. The gap has continued to expand based on the large population increases (around 5-7% this year alone) we have seen in this region over the past 2 years. In looking at our teenage pregnancy rate you will also find that 8.3% of all Hispanic mothers are under the age of 17, which requires us to be aware of the needs of that segment of mothers. With this project we will be meeting numerous community needs and outcomes:

- **Increasing Access to PC physicians**
- **Prenatal Care**
- **Decreased NICU Utilization**

Related Category 3 Outcome Measure(s):

- 135235306.3.3 IT 8.3 Early Elective Delivery

Relationship to other Projects

This project will be in concert with the West Odessa Family Health Clinic, in that this program will supply the providers necessary to provide OB/GYN services in low-income settings. MCHS wants to ensure that the level of care is consistent regardless of health insurance status.

Relationship to Other Performing Providers' Projects in the RHP:

MCHS will be working with Texas Tech Health Science Center on this project. We are currently exploring models that will allow us to integrate high volume OB/GYN practices to meet the expanding needs of the community, while at the same time ensuring that our residents and medical students have ample opportunity to in order to train residents and medical students.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

For this project our valuation revolves around two main elements, project scope and populations served. The creation of a large, multi-site OB/GYN group is a rather large undertaking and the scope of our project will take a great represents great demand on our system over the course of DY 2 and 3. By placing two to four NRP/MW at our FQHC look alike clinics, we will serve low-income patients through a new and innovative model that will give them the support they need for the term of the pregnancy and beyond.

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Women's Program was deemed to be our 3rd most pressing project and therefore was given the 3rd highest allocation.

135235306.1.3	***1.1- Primary Care Capacity***	***1.1.1-Establish More Primary Care Clinic***	***Expansion of Women's Health Services Access in Ector County***
Performing Provider ***Medical Center Health System***		***TPI*** ***135235306***	
Related Category 3 Outcome Measure(s):	***135235306.3.3***	***IT- 8.3***	***Early Elective Delivery***
Year 2 (10/1/2012 – 9/30/2013)	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]: Hire Additional Primary Care Providers for Family Health Clinic (2 NRP/Midwives) Metric 1 [P-5.1] Documentation of increased number of providers (2 NRP/Midwives) Data Source: Documentation of completion. Milestone 1 Estimated Incentive Payment (maximum amount): $1,016,289 Milestone 2 [P-X]: Implementation of Centering Model at Family Health Clinic Metric [P-X.1]: Documentation of planning processes and implementation of program Data Source: Supporting documentation.	Milestone 3: [P-1]: Establish new Primary Women's clinic site on MCHS campus Metric: [P-1.1]: Renovation of existing site to suit multi-specialty group Data Source: Documentation of Site completion Milestone 3 Estimated Incentive Payment (maximum amount): $554,358 Milestone 4 [P-5]: Additional Primary Care Providers for Westside Family Health Clinic and Primary Women's Clinic Site (2-3 OB/GYN and 2 NRP/Midwives) Metric 1 [P-5.1]: Documentation of increased number of providers (1-2 OB/GYNs and 1 NRP/Midwives) Data Source: Documentation of completion Milestone 4 Estimated Incentive Payment	Milestone 7 [I-12]: Increase OB/GYN visit volume over DY 3 Patient Volume Metric 1: [I-12.1]: Documentation of increased visits. Goal: 4,460 Patients Visits Data Source: EHR Milestone 7 Estimated Incentive Payment (maximum amount): $1,106,940 Milestone 8 [P-X, CQI P-3]:Participate in face to face learning collaborative Metric [P-3.1]: Participate or Lead two Perinatal Learning Collaborative Sessions Data Source: Documentation of semiannual meetings	Milestone 9 [I-12]: Increase OB/GYN visit volume over DY 3 Patient Volume Metric 1: [I-12.1]: Documentation of increased visits. Goal: 8,920 Patients Visits Data Source: EHR Milestone 9 Estimated Incentive Payment (maximum amount): $918,559 Milestone 10 [P-X, CQI P-3]:Participate in face to face learning collaborative Metric [P-3.1]: Participate or Lead two Perinatal Learning Collaborative Sessions Data Source: Documentation of

Milestone 2 Estimated Incentive Payment (maximum amount): $1,016,289	(maximum amount): $554,358 Milestone 5 [P-X, CQI P-3]:Participate in face to face learning collaborative Metric [P-3.1]: Participate or Lead two Perinatal Learning Collaborative Sessions Data Source: Documentation of semiannual meetings Milestone 5 Estimated Incentive Payment (maximum amount): $554,359 Milestone 6 [I-12]: Increase OB/GYN visit volume over DY 3 Patient Volume Metric 1: [I-12.1]: Documentation of increased visits. Goal: 2,676 Patients Visits Data Source: EHR Milestone 6 Estimated Incentive Payment (maximum amount): $554,359	Milestone 8 Estimated Incentive Payment (maximum amount): $1,106,940	semiannual meetings Milestone 10 Estimated Incentive Payment (maximum amount): $918,559
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $2,032,578	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $2,217,434	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $2,213,880	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,837,118
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $8,301,010			

Identifying Project and Provider Information:
Category 1.4: Enhanced Interpretation Services and Culturally Competent Care.
Project Option: 1.4.7
Project identification number: 135235306.1.4
Performing Provider: Medical Center Health System TPI: 13523506.

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention: This project will provide additional interpretive services throughout the Health System. Through the implementation of 10 Mobile Interpretation Units (Video Conferencing) we will be able to provide consistent interpretation. In Ector County, 36% of the population list English as a second language, therefore the inability for MCHS to provide consistent interpretation is unacceptable.
- Need for the project: We currently have 20+ interpreters on staff, but many of them are in care roles and have to be taken away to translate. This creates holes on the interpreter's floor and is inconsistent at best. By having readily available interpretation, we will be able to maintain consistency during admission and discharge, which will help reduce readmissions due to confusion.
- Target population: The target population is our patients that need interpretative service either in the inpatient setting to outpatient setting. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to provide interpretative services to all patients in the hospital. We will have units on each floor to ensure rapid turnaround times. Patients Impacted DY3 1800 interpretation sessions, DY4 3000 interpretation sessions, DY5 4200 interpretation sessions
- Category 3 outcomes: IT-6.1 our goal is to increase overall patient satisfaction with this project. We will specifically look at "Communication with Doctor and Nurses" as a measure of success.
- Continuous Quality Improvement: MCHS has a robust CQI plan in place to consistently challenge protocols in order to improve. For this project, we will work with internal and regional stakeholders to perform rapid cycle tests that will improve processes by exposing holes in our program. The region will meet quarterly and the MCHS Interpretation team will meet on a monthly basis.

Communication is one of the foundations of health care. Every health interaction depends on effective communication, and good communication has been proven to support improved patient outcomes, satisfaction, and adherence to treatments and, follow up care.

Medical Center Hospital has struggled to improve the quality of communication we give to our limited English proficiency patients (LEP) for many years due to a lack of resources and clear strategic direction.

The goal of this project is to expand language access services, to assure the highest quality care for all patients regardless of language needs through the implementation of a web based interpreter service.

The advantages of a web based services include ready access, providing on demand language access 24/7, and trained interpreters providing for the communication needs of Limited English Proficient patients as well as the deaf and hard-of-hearing. A 5-year expected outcome for this project includes full implementation and use of language interpretation supported my ready access of trained interpreter services across the continuum of care and in all settings of the health care system.

Project Specifics:

1. Implementation of video-conferencing service to help fill gaps with medical interpretation.
2. Expansion of training for current staff to allow them to better care for their LEP (Limited English Proficient) patients.
3. Updated Policy and Procedures that will streamline our ability to provide access to interpretation.

Relationship to Regional Goals:

RHP 14 has been focused on reducing barriers to care for patients across the region. Language barriers are our most common outside of cost-related barriers. The inability for MCHS and others to provide medically-specific interpretation has reduced our patient satisfaction scores and is a huge contributor to medical errors and therefore readmissions.

5-Year Goals:

- Ensure every unit has an interpreter unit and at least one medically-trained interpreter on the floor at all times.
- Increase patient satisfaction by 10% over DY2 baseline
- Reduce wait times for interpretation to less than 15 minutes.

Challenges/Issues:

- Complete gap analysis of interpreter services
- Evaluate, revise and ensure our policies meet regulatory and legal requirements
- Ensure minimum configuration on existing computer equipment
- More fully integrate cultural competency and awareness material into all staff training opportunities to increase their awareness and adherence to our policy.

Starting Point/Baseline Data (if applicable)

Not applicable. Due to the lack of resources and clear strategic direction mentioned above, Medical Center Health System does not currently have any baseline data for the use of interpreter services. The organization expects to establish its baseline data two years after implementation of this project.

Rationale:

- **This project supports CN 6 as identified in the RHP 14 Needs Assessment.**

There is extensive literature validating the negative impact of language barriers in supporting positive health outcomes. At Medical Center Hospital we understand effective communication is crucial to effective health care because patients need to understand their medications, interventions, and ongoing care. This organization seeks to ensure patients have access to timely, qualified health care interpreter services in their primary language, thereby increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and good outcomes.

Our current interpreter services rely on a limited pool of in-house interpreters, as well as telephonic services as needed. We know the system is not always used when it could or should be. These "failure to utilize" situations are often related to the limited number of available in-house interpreters or insufficient access to the technology available in a timely manner. Our health professionals continue to rely on ad hoc interpreters, such as bilingual employees or patients' relative to provide assistance. The lack of access to trained interpreters can explain to some extent the reliance on ad hoc interpreters.

The implementation of a web based system alone does not ensure that patients' will experience qualified health care interpretation in a timely manner.

Related Category 3 Outcome Measure(s):

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

This organization seeks to ensure patients have access to timely, qualified health care interpreter services in their primary language, thereby increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and good outcomes. HCAHPS questions related to discharge instructions to be used will be:

- Patient has good understanding of managing health
- Patient understanding of purpose of taking medications

Relationship to other Projects

Successful medical care requires patients' participation and full understanding of their care plan, medications, discharge instructions, and follow up care. This is best accomplished when the information is exchanged in the patient's primary language or preferred language. Improved communication will support our efforts in primary care capacity, care transition programs, care navigation, and palliative care.

Relationship to Other Performing Providers' Projects in the RHP:

Realizing the importance of communication in providing effective health care, both Midland Memorial Hospital and Medical Center Health Systems are doing projects in this area targeting the populations in their different counties that utilize their inpatient services (Midland & Ector) (MMH's 136143806.1.4 and MCHS's 135235306.1.4). Both hospitals plan to profit by sharing their experiences in learning collaborative. See below.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

Medical Center Hospital (MCH), part of the Medical Center Health System (MCHS), is a 402 bed community-based teaching hospital serving 17 counties of West Texas and residents of the Permian Basin. Our consumer base is represented by a Hispanic population exceeding 47%. According to county statistics, 36% of the population reports speaking a language other than English at home.

Research studies have documented that the safety and quality of healthcare of LEP patients can be diminished due to language barriers. The implementation of a qualified, on demand interpreter service will improve the delivery of healthcare within the organization, increase the overall health of the community, and bring the organization more in compliance with Federal Laws and regulations.

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, this project was deemed to be our 10th most pressing project and therefore was given the 10th highest allocation.

Milestones and Metrics Table

135235306.1.4	1.4	1.4.7	ENHANCED INTERPRETATION SERVICES AND CULTURALLY COMPETENT CARE
MEDICAL CENTER HEALTH SYSTEM		135235306	
RELATED CATEGORY 3 OUTCOME MEASURE(S):	135235306.3.4	IT 6.1	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-1] Conduct gap analysis Metric 1: [P-1.1] Determine gaps in language access and culturally competent care Data Source: Gap Analysis Milestone 1 Estimated Incentive Payment (maximum amount): $148,429 Milestone 2: [P-3] Implement Language access Policy & Procedures Metric: [P-3.1]Submission policies and procedures Data Source: Policy & Procedures Milestone 2 Estimated Incentive Payment (maximum amount): $148,429 Milestone 3: [P.4]Expand qualified health care interpretation	Milestone 4: [P.4]Expand qualified health care interpretation technology Metric: 1 [P-4.1] Purchase 6 additional audio/video expands to remote site locations. Data Source: Encounter report Milestone 4 Estimated Incentive Payment (maximum amount): $486,430	Milestone 5: [P-7] Train a number or proportion of providers/staff to appropriately utilize health care interpreters. Metric 1: [P-7.1] Expand language access utilization. Data Source: Training materials, class rosters Milestone 5 Estimated Incentive Payment: $239,400 Milestone 6 [I-13]: Improve Language Access Metrics 1: [I-13.1]: The number of qualified health care interpreter encounters per month based on one of the reporting months within the prior year Goal: Increase access to timely, qualified health care interpreter encounters per month by 10% Data Source: Automated reports Milestone 6 Estimated Incentive Payment:	Milestone 7 [I-13]: Expand language access utilization Metric 1 [I-13.1]: The number of qualified health care interpreter encounters per month based on established baseline Goal: Increase the number of qualified health care interpreter encounters per month by 20% Data Source: Automated report Milestone 7 Estimated Incentive Payment (maximum amount): $403,219

technology Metric: [P-4.1]Purchase 10 audio/video units one per acute care units; ED; Radiology; FHC Data Source: Encounter report Milestone 3 Estimated Incentive Payment (maximum amount): $148,431		$239,400	
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $445,289	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $486,430	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $478,800	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $403,219
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $1,813,738			

Project Option 1.1.2 – Expand existing primary care capacity: Recruitment additional primary care providers to RHP14
Unique Project ID: 136143806.1.1
Performing Provider Name/TPI: Midland Memorial Hospital In collaboration with Premier Physicians / 136143806

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Memorial Hospital** is one of the three major hospitals in RHP14 and the only acute care hospital in Midland County--estimated population of 144,500. MMH is a 320-bed not-for-profit acute facility which provides inpatient and outpatient services to all the counties in RHP14. State data shows that approximately 25% of its inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery). **Premier Physicians**, a 501(a) non-profit corporation, was created to assist in the recruitment of providers to the Permian Basin.
Clearly state intervention(s)	Actively recruit family practitioners, pediatricians and mid-level providers to allow Midland and RHP14 residents, particularly those who are Medicaid, low-income or uninsured, greater access to basic healthcare, thereby reducing a patient's waiting time for an appointment.
Brief description of need for the project including appropriate data	Our Region only has 61 primary care physicians per 100,000 people, compared to the state-wide rate of 69.5. HHS has designated all the counties in RHP14 as having "whole" or "partial" shortages of primary care physicians.
Target population – number of patients served – how Medicaid and/or indigent patients will benefit from project	The shortage of physicians in this area makes it difficult for all patients who currently do not have a provider. The phenomenal growth of area population (estimated Midland County population – 144,000) due to the oil boom has only increased this problem. Providers added to Premier Physicians will benefit Medicaid, Medicare, and uninsured patients allowing these individuals greater access to basic health care and increased treatment of high blood pressure issues that affect 33.5% of the population. First year pediatricians will serve an estimated additional 3,000 patient visits with 48% of patients being Medicaid and 3% uninsured. First year, primary care providers will provide an additional 3,050 patient visits with 10% of these being Medicaid patients and 16% uninsured. The expected increase in volume of services will be as follows: DY2 – 1600 patient encounters, DY3 – 6,250 patient encounters, DY4 – 12,400 patient encounters, DY5 – 18,150 patient encounters.
Category 1 or 2 expected patient benefits	Decrease the number of days to secure appointment with a primary care provider at Premier Physicians below the current baseline of nine days.
Category 3 outcomes	IT 1.7 – Controlling high blood pressure - Decrease admissions and mortality linked to high blood pressure and associated ills (heart disease, stroke and renal failure) by aggressively monitoring and treating patients with high blood pressure. RHP14 reports a higher rate of heart disease than that of the Texas statewide rate.
CQI element(s)	N/A

- **Project Description:**

According to the RHP 14 Community Needs Assessment (pages 6-7, 16); primary care providers play an imperative role in providing access to medical care. In 2011, the region reported 61 primary care physicians per 100,000 people, compared to the state-wide rate of 69.5 primary care physicians. All of the counties in the Region have been designated by the U.S. Department of Health and Human Services as having "whole" or "partial" shortages of primary care physicians [CN.3 – Shortages of health care professionals, including primary care physicians and mental health care provider]. Our recruitment project focuses on family practitioners, pediatricians, and mid-level (APRN and/or PA) primary care providers which will target Midland and RHP 14 residents, particularly those who are Medicaid, Medicare, low-income or uninsured, allowing greater access to cost effective, basic health care. Our goal is to increase the number of primary care providers in RHP 14 by recruiting at least 2 additional providers per year for the extent of the demonstration project. The recruits will be added to Premier Physicians, in order to reduce a patient's waiting time for an appointment.

Each physician or midlevel provider recruited will expand the number hours available to see patients by approximately 1800 hours per year. Our recruitment of new providers will include expanding clinic space (2 additional offices), staffing (a minimum of 8 new support staff members over the project years to support 6 new providers) and increasing available hours by setting up new or adding to existing practices and ensuring the continuation of Saturday pediatric clinics. For every Physician added, support staff must be increased by a minimum of two staff members. Should our population require a new location for the physician, the staffing will likely require 3 support staff. Each provider's support staff receive a minimum of 24 hours of training in compliance, operation of the practice management system and electronic medical record, and on-site training.

The expected increase in volume of services will be as follows: DY2 – 1,600 patient encounters, DY3 –6,250 patient encounters, DY4 – 12,400 patient encounters, DY5 – 18,150 patient encounters.

Challenges include cost involved in recruitment, the competitive nature of recruiting the limited number of available providers to a remote location, the need for providers to be bilingual in Spanish/English, and, currently, the housing shortage due to the current energy-related economic boom. Funds from the DSRIP program will assist with the costs involved with recruitment of providers into our remote location. Formerly short term grants from the Midland Development Corp. had funded a part of the recruitment, but this has expired. We hope that the project funding will help with the expiration of this funding and assist in recruiting of primary care physician for our area. Our community as a whole has reacted to the lack of housing, and is building new single dwelling homes, apartments, condominiums, or is seeking opportunities to increase available affordable housing.

As part of our quality improvement effort we will measure the impact of our project by tracking the increased number of patients in our targeted population, tracking days to obtain

an appointment, and monitoring patients presenting with high blood pressure and measuring the control results of the hypertensive treatment.

- **Starting Point/Baseline:**

  We find from our Community Needs Assessment that the region has a lower percentage of physicians that work directly with patients per population than the state-wide average which impacts the number of days for an individual to obtain an appointment with a primary care provider. In September 2012, the average number of days required for an individual to obtain an appointment with one of our primary care providers is nine (9) days.

- **Rationale:**

  RHP 14's Community Needs Assessment indicates that Midland County suffers from a health professional shortage in primary and mental health care for low income individuals, and is a partially medically underserved area. The residents of Midland County, as part of RHP 14, suffer from a higher rate of mortality caused by liver disease, diseases of the colon, chronic respiratory diseases and diabetes than the statewide average [CN.1 High rates of chronic disease], each of which could be screened earlier, monitored, and managed by primary care providers, leading to better, cost effective health outcomes for all patients particularly those with access barriers based on income [CN.6]. Residents in RHP 14 also suffer from a higher rate of obesity and teen births than the state-wide average, which are linked to health and lifestyle choices that primary care providers can address with regular access to patients. Finally, between 2005 and 2010, RHP 14 had 24,464 potentially preventable hospitalizations at an estimated cost of $461,193,683.

  The data above shows that patients in Midland County and RHP14 need access to primary care providers, whose interventions can lead to the related regional goals of better health outcomes, chronic disease management, lifestyle adjustments, and prevention of unnecessary ED visits, and expensive hospital admissions and re-admissions [CN.2 – High Cost associated with preventable hospitalizations admissions and readmissions].

- **Related Category 3 Outcome Measure(s):**

  Controlling High Blood Pressure IT-1.7. Our recruitment will focus on family practitioners which will allow Midland residents greater access to basic health care. 33.5 percent of the people in the United States have high blood pressure and RHP 14 reports a higher rate of heart disease than that of the Texas statewide rate. Clinical trials have shown aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure, results that are particularly striking in elderly hypertensives. RHP 14's percentage of older adults is expected to grow in the next 20 years, which will present greater requirements for basic health care. Guidelines from the USPSTF and the Joint National Committee indicate 53% percent of people under treatment achieved control of their blood pressure.

- **Relationship to other Projects:**

  Project 1.1.2 supports and will reinforce the effectiveness of Project 1.6 (Provide Urgent Medical Advice), providing options for directing patients seeking primary care providers. Additional primary care providers will reduce access delays and decrease avoidable utilization of Urgent Care and ED services.

  Category 4 population focused measures: The ability to establish a relationship with a primary care provider and see the provider when needed should impact potentially preventable admissions, 30-day readmissions and improve patient-centered healthcare**.**

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

  Midland Memorial, like Winkler [094204701.1.1] and Andrews [127298103.1.1], has a project to recruit primary care providers It is anticipated that these providers will be geographically isolated due the extensive area encompassed by RHP14, thereby avoiding any duplication.

- **Project Valuation:**

  In determining the value of this project, Midland Memorial analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community. Specifically, the recruitment of six additional primary care providers into the community meets the express goals of the Waiver, addresses the needs of the federally designated shortage of primary care providers in Midland County, and will add great value by improving patient health outcomes. Additionally, the recruitment, retention, and training of new providers will take considerable time, effort, and resources to accomplish, making this a higher value project than others that is easier to implement.

136143806.1.1	***1.1.2***	***1.1.2A*** ***1.1.2B*** ***1.1.2C***	***EXPANDING PRIMARY CARE***	
Midland Memorial Hospital				*136143806*
Related Category 3 Outcome Measure(s):	***136143806.3.1***	***IT 1.7***	***Controlling High Blood Pressure***	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-5. Train/hire additional care providers and staff and/or increase the number of primary care clinics for existing providers. By the end of DY2, two (2) primary care providers will have been recruited to the County increasing the additional number of available annual patient encounters by 1,600 over base year (DY1). Metric P-5.1. Documentation of increased number of providers and staff and/or clinic sites. Data Source P-5.1.a. 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 *(maximum amount):* $1,626,657	Milestone 2 P-5. Train/hire additional care providers and staff and/or increase the number of primary care clinics for existing providers. By the end of DY3, two (2) additional primary care providers will have been recruited to the County increasing the additional number of available annual patient encounters by 6,250 over base year (DY1). Metric P-5.1. Documentation of increased number of providers and staff and/or clinic sites. Data Source P-5.1.a. 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: $1,663,683	Milestone 3 P-5. Train/hire additional care providers and staff and/or increase the number of primary care clinics for existing providers. By the end of DY4, two (2) additional primary care providers will have been recruited to the County increasing the additional number of available annual patient encounters by 12,400 over base year (DY1). Metric P-5.1. Documentation of increased number of providers and staff and/or clinic sites. Data Source P-5.1.a. Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation Milestone 3 Estimated Incentive Payment: $1,305,153	Milestone 4 I-10. Enhance patient access to primary care services by reducing days to third next-available appointment. Demonstrate improvement over prior reporting year. By the end of DY5, the increase in the number of primary care providers employed by Premier Physicians (by a total of 6) will facilitate a reduction in the time period for the third available appointment with the provider/care team from 9 days to no more than 5 days and increasing the additional number of available annual patient encounters by 18,150 over base year (DY1). Metric I-10.1.a. Average Number of days to third next appointment for an office visit for each clinic. Data Source I-10.1.b. Information from Scheduling Software to show the length of time in calendar days Milestone 4 Estimated Incentive Payment: $1,031,742

136143806.1.1	***1.1.2***	***1.1.2A*** ***1.1.2B*** ***1.1.2C***	***EXPANDING PRIMARY CARE***	
Midland Memorial Hospital				*136143806*
Related Category 3 Outcome Measure(s):	***136143806.3.1***	***IT 1.7***	***Controlling High Blood Pressure***	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $1,626,657	Year 3 Estimated Milestone Bundle Amount: $1,663,683		Year 4 Estimated Milestone Bundle Amount: $1,305,153	Year 5 Estimated Milestone Bundle Amount: $1,031,742
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $5,627,235				

Project Option 1.6.2 – Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care: Enhance urgent medical advice by expanding access to 68NURSE services

Unique Project ID: 136143806.1.2

Performing Provider Name/TPI: Midland Memorial Hospital / 136143806

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Memorial Hospital** is one of three major hospitals in RHP14 and the only acute care hospital in Midland County—est. population of 144,500. A 320-bed not-for-profit acute care facility, it provides inpatient/outpatient services to all the counties in RHP14. State data shows that approximately 25% of its inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery).
Clearly state intervention(s)	Promote in selected RHP counties other than Midland, the "68NURSE" telephone nurse triage program, via a toll free number and various local marketing initiatives. Establish buy-in from various small hospitals in the region. By integrating 68Nurse with a referral system to appropriate local providers, barriers to care (CN.6) can be reduced and the high costs associated with non-emergent ED utilization and hospital admissions and readmissions (CN.2) can be lowered. Establishment of a provider referral system will include enhanced communication though direct email and fax communication of patient medical needs to the provider.
Brief description of need for the project including appropriate data	Between 2001 and 2010, emergency room use in Texas has increased by 29%. RHP14 has a high uninsured population; specifically, 32% of adults and 19% of children are uninsured in RHP14 and use the ED for primary care. 68Nurse, using established protocols, triages patients based on their chief complaint to the appropriate level of care.
Target pop. – # of patients served – how Medicaid and/or indigent patients will benefit from project	Target population is any 18+ year old adult living in RHP14 no matter their financial standing. Expansion into surrounding counties will be staged with efforts focused on Ector/Andrews (300-380) starting in DY3, Howard/Martin (200-300) starting in DY4 and Glasscock/Crane/Upton (50-100) starting in DY5. Figures in parentheses represent approximate number of additional calls per year over baseline added from each area.
Category 1 or 2 expected patient benefits	If we can develop referral systems to local physicians and clinics for all patients, whatever their financial status, we can redirect non-emergent patients to the appropriate level of care, freeing up local Emergency Rooms to handle truly emergent cases and decrease throughput.
Category 3 outcomes	IT 9.2 – ED Appropriate Utilization - Reduce inappropriate, expensive utilization of EDs by providing resources to community residents for healthcare needs by a percentage to be determined in DY2 as part of the expansion. The advice line triages patients to the appropriate place for care and provides appointments for the residents in clinics or with primary care providers.
CQI element(s)	Quarterly meetings with leadership within the region to discuss impact and issues particularly effectiveness of referrals to non-ED venues.

- **Project Description:**

  RHP14's Community Needs Assessment (see page 14: "Preventable Hospitalizations" and page 16: "Summary: Demand and Need for Services) states that emergency room use in Texas has increased by 29% between 2001 and 2010. Furthermore, RHP14 has a high uninsured population which increases the inappropriate use of the emergency room. Specifically, 32% of adults and 19% of children are uninsured in RHP14. In an effort to improve appropriate utilization of ED services and lower preventable hospital admissions and readmissions [CN.2], the 68NURSE telephone triage program was developed in July 2009 to provide medical advice to community residents funded solely by Midland Memorial. Our project includes all 4 core components. (a) Our goal is the expansion of this program which already has a process for triaging patients in a timely manner and surveying them to ensure patient satisfaction with the service. (b)Included in our expansion plans is the development of linkages between the triage service and one or more local primary care providers thereby eliminating some of the perceived barriers to care experienced by some of our disparate populations [CN.6] if only through unawareness of their options for care. (c) Lastly, it is our intention to meet at least quarterly with Regional leadership to discuss and evaluate opportunities to scale the project to a larger population and create other linkages.

  How the expansion would work: By using established protocols, patients are triaged based on their chief complaint and associated signs or symptoms to the most appropriate level of care. To further address the growing unassigned population, Midland Memorial Hospital plans to regionalize 68NURSE. MMH's DSRIP plan includes: (1) Provide toll free access to 68NURSE for non-local residents; (2) Partner with other RHP communities to provide the service for their community residents; (3) Enhance marketing initiatives to increase awareness to the RHP residents of the existence and capabilities of 68NURSE triage line; (4) Increase RN staffing levels of 68NURSE to ensure adequate coverage during documented peak call times. Our goal is to increase utilization of 68NURSE line by RHP14's residents and decrease utilization of MMH's and other RHP14 acute care facilities' EDs by non-emergent patients. Our biggest challenges are patient awareness and acceptance of this service as a clinic resource.

- **Starting Point/Baseline:**

  68NURSE was initiated to reduce inappropriate ED visits and provide resources for community residents to receive the appropriate level of care at the appropriate location. Initial call volumes averaged 80 calls per day and focused on residents in the local community. Marketing efforts included mail outs, participating in local health fairs, and advertising within the local community. Staffing plans provided 2 RNs at peak call times between the hours of 10 am and 10 pm, which sufficiently covered the nurse call volumes. Total nursing hours per day were 36 RN hours. In the initial six months of assistance (July-Dec 2009), 68Nurse triaged 6,146 calls of which 5,481 identified themselves as living in Midland. Of these 5,481 calls, 3,752 were unduplicated and represented approx. 4% of the adult population of Midland County. In 2012, 2.5 years after starting the Program, 68Nurse triaged 27,271 calls (total calls = 41,490) of which only 7,373 or 27% were directed to the ED. Of the total 27,271 calls, 17,062 were known to be from Midland County. Of that number, 11,826 were unique callers

and represented approximately 11% of the current estimated adult Midland population. Of the total 17,062 separate calls from Midlanders, 20% (3,327) self-reported that they were pre-disposed to going to the ER but called the service instead because it was available. We hope to do as well in our other targeted population.

We already have a presence in Ector and Andrews counties and will work to increase service penetration by 5% over our current levels (approximately 300-380 additional calls per year for DY 3-5). We have little or no penetration in the five other counties: Howard, Martin, Crane, Glasscock and Upton and therefore no history on which to base our goals. Therefore, if we base the numbers of anticipated calls as a percentage of the adult population: we estimate volume for Howard and Martin counties combined, starting in DY4, will be between 200-300 calls and for Crane, Glasscock and Upton counties combined, starting in DY5, to be between 50-100 calls. Total DY5 goal is to increase the number of calls handled by the 68Nurse Call Center to at least 8,400 calls from the 7 county-area which would represent a 3.9% call increase over CY2012.

- **Rationale:**

  Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care thereby decreasing possible preventable hospital admissions and readmissions [CN.2] as well as lowering or eliminating some of the perceived barriers to care experienced by some of our disparate populations [CN.6] if only through unawareness of their options for care.

- **Related Category 3 Outcome Measure(s):**

  OD-9.Right Care, Right Setting. IT-9.2. ED appropriate utilization resulting in the reduction of all ED visits including those for ambulatory care sensitive conditions. 68NURSE positively impacts ED utilization by providing resources to community residents for healthcare needs. The advice line triages patients to the appropriate place for care and provides appointments for the residents in clinics or with primary care providers rather than going to the ED.

- **Relationship to other Projects:**

  Project 1.6.2 supports and will reinforce the effectiveness of Project 2.9.1, Patient Navigation Program. The 68NURSE line will provide consistent protocols and access to urgent care appointments for EMS patients not requiring emergent care. The appointment access will be available to area residents calling the medical advice line directly and EMS patients needing further non-emergent medical attention. The presence of an Advanced Practice Nurse on the EMS unit is another resource to provide immediate guidance or treatment for non-emergent patients and reducing inappropriate use of the ED.

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

- **Plan for Learning Collaborative:**

  RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

- **Project Valuation:**

  The valuation of each MMH project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community by addressing quality patient care in a cost efficient model and attempting to reduce unnecessary ED visits and better use of care. Between 2005 and 2010, potentially preventable hospitalizations resulted in approximately $461 million in charges. When considered in light of patient health outcomes and quality/quantity of life, MMH must strive to direct care to more appropriate utilization. This will result in better health outcomes for patients. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run.

136143806.1.6.2	*1.6.2*	*1.6.2.A* *1.6.2.B* *1.6.2.C*	**Enhancing urgent medical advice by expanding access to 68NURSE services**
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.2***	***IT 9.2***	***ED Appropriate Utilization***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2. Collect baseline data on current number of calls received from patients within Midland and the surrounding counties in the RHP. Metric P-2.1. Documentation of Baseline Assessment Data Source P-2.1.a. Documentation of call volume from patients within targeted counties and population count for each target. Milestone 1 Estimated Incentive Payment *(maximum amount):* $894,661	Milestone 2 I-13. Increase the number of patients that accessed the nurse advice line from Andrews and Ector counties by at least 5% of current base rate -resulting in an increase of 300-350 additional calls per year. Targeted population: Ector and Andrews Counties Metric I-13.1.a & b Increase the penetration of 68Nurse within the targeted population by at least 5% from DY2 baseline rate. Number of targeted patients that access nurse advice line / Number of patients within the targeted population (adults in each targeted county) Data Source P-13.1. Documentation from Call System records Milestone 2 Estimated Incentive Payment: $915,026	Milestone 3 I-13. Increase the number of patients that accessed the nurse advice line from Howard and Martin counties to be at between 200-300 calls for DY 4. Targeted population: Howard and Martin Counties Metric I-13.1.a & b Increase the penetration of 68Nurse within the targeted population by at least 1% of estimated adult population of targeted counties in DY2. Number of targeted patients that access nurse advice line / Number of patients within the targeted population (adults in each targeted county) Data Source P-13.1. Documentation from Call System records Milestone 3 Estimated Incentive Payment: $717,834	Milestone 4 I-13. Increase the number of patients that accessed the nurse advice line from Crane/Glasscock and Upton counties to be between 50-100 calls for DY5. Targeted population: Crane, Glasscock and Upton Counties Metric I-13.1.a & b Increase the penetration of 68Nurse within the targeted population by at least 1% of estimated adult population of targeted counties in DY2. . Number of targeted patients that access nurse advice line / Number of patients within the targeted population (adults in each targeted county) Data Source P-13.1. Documentation from Call System records Milestone 4 Estimated Incentive Payment: $567,458

136143806.1.6.2	*1.6.2*	*1.6.2.A* *1.6.2.B* *1.6.2.C*	**Enhancing urgent medical advice by expanding access to 68NURSE services**
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.2***	***IT 9.2***	***ED Appropriate Utilization***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $894,661	Year 3 Estimated Milestone Bundle Amount: $915,026	Year 4 Estimated Milestone Bundle Amount: $717,834	Year 5 Estimated Milestone Bundle Amount: $567,458
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,094,979			

Project Option 1.1.1 – Establish more primary care clinics: Establishment of Women's Clinic in an Underserved Area

Unique Project ID: 136143806.1.3

Performing Provider Name/TPI: Midland Memorial Hospital / 136143806

In collaboration with Midland Community Health Care Services (local FQHC)

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Community Health Care Services** (MCHS) has been an FQHC since 2006, though the clinics have been operational for over 18 years. MCHS sees over 14,000 individual patients via 60,000 office visits annually for primary care. **Midland Memorial Hospital** is one of the three major hospitals in RHP14 and the only acute care hospital in Midland County-- estimated population of 144,500. MMH is a 320-bed not-for-profit acute care facility which provides inpatient and outpatient services to all the counties in RHP14. State data shows that approximately 25% of its inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery).
Clearly state intervention(s)	Establishment of low income women's health clinic within the already existing Coleman clinic located in a HSPA designated area, emphasizing pregnancy testing, early prenatal care and family planning services.
Brief description of need for the project including appropriate data	According to RHP14's Community Need Assessment – anticipated reduction of 66% in DSHS funding for women's services plus this region's adolescent pregnancies rate is 8% points higher than the State average (29.4 vs. 21.4). MCHS's data-percentage of pregnant women who were seen in their first trimester = only 72% of the initial visits**.**
Target population – number of patients served – how Medicaid and/or indigent patients will benefit from project	Target clientele -- young, low-income, Medicaid eligible or uninsured individuals living within the HSPA designated area. Many in the target population are handicapped by educational, cultural and language barriers which inhibit them from timely accessing pregnancy testing and early prenatal care. MCHS' current patient population in the target group is slightly more than 1400, of which only 16% have private health insurance. The remaining patients are largely Medicaid (49%) with the balance being CHIPS (15%), Medicare (1%) and Self Pay (19%). Through this intervention, we estimate seeing per DY a decrease in the percentage of missed first trimester visits from the current 72% to a nominal 90% at the end of the period. This represents an additional 100 -200 prenatal patients in their first trimester--greatly reducing the possibility of these cases being referred to a NICU. This action has the potential to reduce the financial impact to Medicaid by an average cost of $35K for each avoided NICU baby admission.
Category 1 or 2 expected patient benefits	Increased availability of hours for patient visit. Based on currently available information and our current patient levels, this project targets an increase of the initial visits of pregnant women seen by MCHS will be in their first trimester of pregnancy.
Category 3 outcomes	IT 8.2-% of Low-Birth Weight Births – Reduce the number of low birth weight newborns delivered within the region whose mothers live in Midland by a percentage to be determined as part of this initiative.

CQI element(s)	N/A

- **Project Description:**

  Our goal is to establish a new clinic solely for women's health within an existing medical clinic. MCHS' Coleman Clinic is located in a medically-underserved area of Midland. The target clientele are generally young, low-income and uninsured. For many of the patients, educational, cultural and language barriers may discourage timely access to pregnancy testing and early prenatal care. We want to remove the barriers to obstetrical care for low-income women in this medically-underserved area of Midland and improve access to first trimester prenatal care. According to RHP 14's Community Needs Assessment the number of women served by the Department of State Health Services' family planning programs will be cut by 71% and spending for 2012-2013 will be reduced by 66%. In addition to this broad reduction in women's services, in RHP 14, 9% of newborns have a low birth weight and 40% of pregnant women in the region do not receive prenatal care during their first trimester of pregnancy. (See page 10, Section "Fertility and Natality" and Table U, page 21 in RHP14_Supporting Data). [CN.7 – Need for improvement in prenatal and perinatal care.]

- **Starting Point/Baseline:**

  Number of pregnant women who were seen in their first trimester at MCHS (December 2011) = 72% of initial visits

- **Rationale:**

  One of Texas's many health care challenges is to provide access to care for low income women to reduce the high and growing rates of pre-term births, births too close together causing medical risks for the newborn, and births to unmarried teen moms. [(1)] Additionally, RHP 14 rate of adolescent pregnancies is eight percentage points higher than the Statewide average (29.4 vs. 21.4), with 1 in 5 teenagers being completely uninsured. [(2)] Midland Memorial Hospital will be providing funding and other support to assist Midland Community Healthcare Services to establish a low-income women's health clinic at its Coleman Clinic site in southeast Midland, emphasizing pregnancy testing, early prenatal care and family planning services.

- **Related Category 3 Outcome Measure(s):**

  OD-8. Perinatal Outcomes. IT-8.2 Percentage of Low Birth weights births (CHIPRA/NQF #1382)

  For DY2, the project will focus on establishing baseline numbers of low birth weight newborns, delivered within the region, whose mothers live in Midland. For DY3-5, our outcome measure will be IT-8.2 (Percentage of low birth weight births). Premature delivery

---

[(1)] RHP14 Community Needs Assessment, pg. 10

[(2)] RHP14 Community Needs Assessment, pg. 10 & RHP CNA Supporting Data, Table A (pg. 2) and Table O (pg. 15)

and low birth weight are common results of inadequate prenatal care, and can lead to high cost NICU stays, a variety of birth defects, and resultant long-term disability. Early diagnosis of pregnancy and referral for prenatal care in the first trimester can improve outcomes for uninsured patients who might otherwise experience delayed prenatal care. We believe that the availability of culturally-sensitive obstetrical/gynecological services, in a familiar and safe environment within the underserved area, provides a pathway to prenatal care for low income mothers.

- **Relationship to other Projects:**

  Project 6.1 – Health Promotions, will benefit this project by helping to educate potential new mothers and to identify candidates for care in the Women's Clinic.

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

  All three hospitals and Texas Tech in RHP14 understand the importance of increasing low income women's access to healthcare and are doing projects involving expansion of access to Women's health services [MCS #135235306.1.3, Tech's 081939301.1.4 & 2.4 as well as ORMC's 112711003.1.5]. MMH's project, with its creation of a women's clinic within a current clinic located on the southeastern side of Midland, is focused exclusively on low income women of Midland County and not on patients residing in Ector or any of the other counties in our region, therefore avoiding any duplication of services.

- **Plan for Learning Collaborative:**

  RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

- **Project Valuation:**

  The valuation of Midland Memorial's Women's Clinic project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project aims to improve access to care, quality of care and health outcomes by expanding the availability of women's healthcare providers in the region. This effort is designed to bring care to area residents who might not have access, particularly those who are uninsured, underinsured, or receive care through government programs. Additionally, the community needs assessment reflects a need for greater pre-natal care, which this project aims to address. This will benefit the entire community by freeing up resources to provide additional care when needed and deliver care to those who might not otherwise seek it.

136143806.1.3	***1.1.1***	***-***	***Establish Women's Clinic in Underserved Area***
Midland Memorial Hospital			*136143806*
Related Category 3 Outcome Measure(s):	***136143806.3.3***	***IT 8.2***	***Perinatal Outcomes: Percentage of Low Birth Weight Births***

Year 2 (10/1/2012 – 9/30/2013)	**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 By end of DY2, Midland Community Healthcare Services will hire an advanced practice RN or physician's assistant and establish a full-time women's clinic at its Coleman Clinic site in southeast Midland. Metric P-1.1. Number of additional clinics or expanded hours or space Documentation of hiring of mid-level provider, clinic hours. Establishment of baseline percentages of MCHS patients experiencing initial prenatal visit in each trimester of pregnancy, for period October 1, 2012-September 30, 2013. Data Source HR records and Scheduling Software Milestone 1 Estimated Incentive Payment *(maximum amount):* $975,994	Milestone 2 I-12. Increase primary care clinic volume of visits by approximately 100. Show evidence of improved access for patient seeking services. By end of DY3, 73% of the initial visits of pregnant women seen by MCHS will be in the first trimester of pregnancy Metric I-12.1. Documentation of increase number of visits. Demonstrate improvement over prior reporting period. Baseline for DY2. Data Source EHR Milestone 2 Estimated Incentive Payment: $998,210	Milestone 3 I-12. Increase primary care clinic volume of visits by an additional 150 over base year. Show evidence of improved access for patient seeking services. By end of DY4, 75% of the initial visits of pregnant women seen by MCHS will be in the first trimester of pregnancy Metric I-12.1. Documentation of increase number of visits. Demonstrate improvement over prior reporting period. Baseline for DY2. Data Source EHR Milestone 3 Estimated Incentive Payment: $783,092	Milestone 3 I-12. Increase primary care clinic volume of visits by an additional 200 over base year. Show evidence of improved access for patient seeking services. By end of DY5, 80% of the initial visits of pregnant women seen by MCHS will be in the first trimester of pregnancy Metric I-12.1. Documentation of increase number of visits. Demonstrate improvement over prior reporting period. Baseline for DY2. Data Source EHR Milestone 4 Estimated Incentive Payment: $619,045
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $975,994	Year 3 Estimated Milestone Bundle Amount: $998,210	Year 4 Estimated Milestone Bundle Amount: $783,092	Year 5 Estimated Milestone Bundle Amount: $619,045

136143806.1.3	***1.1.1***	***-***	***Establish Women's Clinic in Underserved Area***	
Midland Memorial Hospital				*136143806*
Related Category 3 Outcome Measure(s):	***136143806.3.3***	***IT 8.2***	***Perinatal Outcomes: Percentage of Low Birth Weight Births***	
Year 2 (10/1/2012 – 9/30/2013)	**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):* $3,376,341				

Project Option 1.4.1 – Enhance Interpretation Services and Culturally Competent Care: Expansion of Remote Video/Voice Interpretation Services
Unique Project ID: 136143806.1.4
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806

Summary	
Provider Description: Type, size & role in region's health care infrastructure	Midland Memorial Hospital is one of the three major hospitals in RHP14 and the only acute care hospital in Midland County-- estimated population of 144,500. MMH is a 320-bed not-for-profit acute care facility which provides inpatient and outpatient services to all the counties in RHP14. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery).
Clearly state intervention(s)	To increase the number of qualified medical interpreters and to expand video/voice LAS services beyond current 3 units consolidating all languages including ASL hospital wide, enhancing effective communication with (LEP) patients and their families, resulting in increased patient satisfaction and improved outcomes--reducing readmission rates. As we implement the expansion, we will review/update LAS policies/procedures to meet federal and state guidelines, train staff/providers how to access LAS, and modify our verbal and written offers to LEP patients.
Brief description of need for the project including appropriate data	MMH's diverse LEP patient population is approximately 25% of patients served. Enhancing interpretation services provides an interactive communication infrastructure to LEP patients and their families; and, to MMH's staff/physicians during healthcare encounters. In turn, effective and expedient communication facilitates mutual understanding of assessment, appropriate diagnosis, agreeable treatment options and acute or chronic illness education transcending to better patient satisfaction scores, compliance with treatment plans, and lower readmission rates.
Target pop. – # of patients served – how Medicaid and/or indigent patients will benefit from project	The target population includes LEP patients, specifically but not limited to Medicaid and indigent patients. The aim is to offer LAS services to 100 or more patients per month. Medicaid and indigent patients will benefit from interpretation services enhancement by reducing barriers to healthcare access in their primary language, allowing them to better navigate the healthcare system and helping them better understand the resources available in their community.
Category 1 or 2 expected patient benefits	Historically, approximately 15% of LEP and indigent patients might find it difficult to access healthcare due to language barriers. Improving language access services hospital-wide by a minimum of 5% yearly over the baseline of 96 monthly encounters will extend a pathway to improved access in DY3 105, in DY4 110 and in DY5 115 encounters by month.
Category 3 outcomes	IT 3.1-All Cause 30 Day Readmission Rate - Historically, approximately 0.5% to 0.7% of LEP and indigent patients are readmitted to MMH for all cause reasons. Effective communication with these patients in their primary language will assist MMH in reducing all-cause 30 day readmissions.
CQI element(s)	MMH and Medical Center (Odessa) plan to meet regularly to talk about best practices and successes with regard to language access services and cultural sensitivity programs within our organizations.

Project Description:

- Our project 1.4.1 – Enhance Interpretation Services and Culturally Competent Care: Expansion of Remote Video/Voice Interpretation Services, core components are: a) MMH's total diverse LEP patient population is approximately 25% which identifies a gap in language access. In addressing this gap, we currently have a Qualified Spanish Medical Interpreter (QSMI) training program for our bilingual staff; and audio and contracted American Sign Language (ASL) services. Once qualified, the staff member can be pulled from their primary duties to interpret and be on call at least twice a month. b) We have policies and procedures that address when and how to activate LAS 24/7 by provider/staff via the Cultural Diversity Program, on-call QSMI or house supervisor. Thus, it may be difficult for our QSMI to respond expediently to each request; and, at times challenging to obtain a one-on-one, audio or contracted qualified medical interpreter. Our goals are: first, to expand language access services (LAS) to Limited English Proficiency (LEP) patients in a timely manner d) by increasing qualified health care interpreters and incorporating audio/voice interpretation services, increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and better health outcomes; c) secondly, to train providers and staff on when and how to appropriately utilize qualified health care interpretation services; thirdly, to review and update LAS policies and procedures set in place to meet federal and state regulations; and lastly, to modify our verbal and written offers to LEP patients. Specifically, this project aims to increase language access for video/audio interpretation services beyond the baseline of 3 units hospital-wide by DY3 and enhance processes to aid the provider/staff using LAS to communicate effectively with LEP patients. This will increase the number of qualified health-care-interpreter encounters beyond the baseline of 96 encounters per month. Increased LAS access and appropriate LAS offer to LEP will result in increased patient satisfaction, adherence to prescribed protocols, and safer, more effective treatment (based on more accurate assessment and diagnoses). Challenges include recruiting and training qualified Spanish Medical Interpreters, training staff to access the services, obtaining video/voice interpretation services and community outreach.

- **Starting Point/Baseline:**

  From 2008 to 2012 we have trained over 20 qualified medical interpreters. Our hospital data shows 96 qualified health-care interpreter encounters per month when LEP patients attempted to access healthcare in Midland Memorial's fiscal year 2011. In fiscal year 2012, we initiated a pilot program of video/audio interpretation services with 3 units in three departments to better serve our LEP patients.

- **Rationale:**

  Our total diverse LEP patient population is approximately 25% to 35% of the patients we serve. To provide safe and effective care, open communication, adherence to protocols, and good health outcomes for these patients, it is critical to maintain effective and expedient communication with patients in their primary language.

We currently have a Qualified Spanish Medical Interpreter training program for our bilingual staff. Once qualified, the staff member can be pulled from their primary duties to interpret and be on-call at least twice a month. However, our hospital has two campuses (Main and West) with inpatient and outpatient services. These patients can access healthcare via emergency rooms, outpatient services and direct admission. Thus, despite the training program already in place, it may be difficult for our Qualified Spanish Medical Interpreters to respond expediently to each request, which causes a lapse in the quality of care for some LEP patients. In addressing this challenge, we propose expanding remote video/audio interpretation services hospital wide to respond more efficiently to LEP patients' needs and to train staff / providers on how to access LAS.

Between 2006 and 2010, 12.7% of the Spanish speaking population reported lack of fluency in English. Furthermore, 48% of the population in the region identified themselves as Hispanic in 2011. (Community Needs Assessment, "Population and Counties", page 2 and Table A, page 2 in Data Addendum).

Related Category 3 Outcome Measure(s):

IT-3.1 All cause 30 days readmission rate--
Enhanced communication between staff/physician and patients and their families should result in more positive health outcomes leading to lower readmission rates because patients understand discharge instructions and plans of care. According to Lindholm's (et al) article entitled *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates* published on April 18, 2012 in the Journal of General Internal Medicine, "interpretation at admission seems to be especially important as it has the greatest impact on LOS [Length of Stay]. This intuitively makes sense since a patient's history accounts for approximately 70% of the necessary information to formulate a correct diagnosis…. The likelihood of a patient being admitted within 30 days of discharge seems to be associated with having an interpreter at either admission or discharge." MMH has adopted and implemented patient-centered care models into professional practice, which promote patient autonomy and extend cultural sensitivity, aiding in lower readmission rates.

- **Relationship to other Projects:**

Enhancing interpretation services and culturally competent care provides a communication and interactive infrastructure to Midland Memorial Hospital. It supports our LEP patient demographics by providing an avenue to medical care, reinforces our Synergy and Sunrise Models during the delivery of patient-centered care, enhances communication between staff/physician and LEP patients and their families for positive healthcare outcomes (i.e.: admission data collection, discharge teaching, informed consent, interdisciplinary encounters, 68Nurse telephone nurse triage program, diabetes and nutrition teaching, palliative care program, health promotions, stroke program, etc…), and descends to higher patient satisfaction scores.

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

  Realizing the importance of communication in providing effective health care, both Midland Memorial Hospital and Medical Center Health Systems are doing projects in this area targeting the populations in their different counties that utilize their inpatient services (Midland & Ector) (MMH's 136143806.1.4 and MCHS's 135235306.1.4). Both hospitals plan to profit by sharing their experiences in learning collaborative. See below.

- **Plan for Learning Collaborative:**

  Included in the Permian Basin are Midland County and Ector County. Between both communities, demographics for Hispanic populations average 50%. Thus, Midland Memorial and Medical Center Hospitals collaborating and sharing evidenced-based practices elaborates new ideas and solutions regarding LAS and cultural sensitivity. The two hospitals plan to meet regularly to talk about language access services and cultural sensitivity programs within our organizations to assist our LEP population access healthcare and enhance patient satisfaction. Discussion should center on the challenges that LEP patients face in accessing healthcare, while considering availability of language access services and leveraging them against evidenced based practices. Additional elaboration should include current LAS resources, video / audio technology, readmission rates, data collection and cultural sensitivity. Lastly, the gathering should stir up a quest for better LAS measureable solutions and cultural sensitivity to improve LEPs patient's quality of life.

- **Project Valuation:**

  The valuation of Midland Memorial's Interpretive Services project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. By improving more patients' ability to communicate with providers, Midland Memorial will encourage more people to seek treatment, help improve quality of care, and the eventual outcomes related to follow-up communications. Midland Memorial expects to serve a substantial community need as 25% to 35% of our patients have limited English communication skills. Nearly a quarter of the region's population speaks Spanish as their primary language, providing a huge potential impact for this project. Additionally, this project should have a good return on investment for the expenditure involved because of the potential repeated use of this technology and associated skill development. Patients with better access to timely, qualified health care interpreter services in their primary language should increase the likelihood of safe and effective care, open communication, adherence to treatment protocols, and better health outcomes.

136143806.1.4	***1.4.1***	***1.4.1.A*** ***1.4.1.B*** ***1.4.1.C*** ***1.4.1.D***	***Enhance Interpretation Services and Culturally Competent Care***
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.4***	***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-4. Expand qualified health care interpretation technology Expand language access services hospital-wide by expanding video/voice interpretation services beyond the baseline of 3 video units. Metric P-4.1. Video or audio conferencing interpreter terminals and/or areas/units of the Performing Provider with access to health care interpretation technology. Expand language access services hospital-wide by expanding video/voice interpretation services beyond the baseline of 3 units. # terminals available each unit Total # of video terminals Data Source contract/purchase orders Milestone 1 Estimated Incentive Payment *(maximum amount):* $894,661	Milestone 2 -A I-13. Improve language access Improve language access services hospital-wide by achieving a 10% (105) increase beyond the baseline of 96 encounters per month. Metric I-13.1. The number of qualified health care interpreter encounters per month within the prior year. Total # of remote video/voice and/or in-person interpreter encounters recorded per month Total # of encounters per month in prior year Data Source Automated report from Martti system Milestone 2A Estimated Incentive Payment: $686,270	Milestone 3-A I-13. Improve language access services hospital-wide by achieving a 5% (110) increase beyond the DY3 encounters per month. Metric: 1-13.1 The number of qualified health care interpreter encounters per month within the prior year. Total # of remote video/voice and/or in-person interpreter encounters recorded per month Total # of encounters per month in prior year Data Source Automated report from Martti system Milestone 3A Estimated Incentive Payment: $538,376	Milestone 4-A I-13. Improve language access services hospital-wide by achieving a 5% (115) increase beyond the DY4 encounters per month. Metric: 1-13.1 The number of qualified health care interpreter encounters per month within the prior year. Total # of remote video/voice and/or in-person interpreter encounters recorded per month Total # of encounters per month in prior year Data Source Automated report from Martti system Milestone 4A Estimated Incentive Payment: $425,594

136143806.1.4	*1.4.1*	*1.4.1.A* *1.4.1.B* *1.4.1.C* *1.4.1.D*	*Enhance Interpretation Services and Culturally Competent Care*
Midland Memorial Hospital			*136143806*
Related Category 3 Outcome Measure(s):	*136143806.3.4*	*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-B 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 similar interpretative project. Metric P-10.1. 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 meetings. Milestone 2B Estimated Incentive Payment: $228,756	Milestone 3-B 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 similar interpretative project. Metric P-10.1. 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 meetings. Milestone 3B Estimated Incentive Payment: $179,458	Milestone 4-B 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 similar interpretative project. Metric P-10.1. 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 meetings. Milestone 4B Estimated Incentive Payment: $141,864
Year 2 Estimated Milestone Bundle Amount: $894,661	Year 3 Estimated Milestone Bundle Amount: $915,026	Year 4 Estimated Milestone Bundle Amount: $717,834	Year 5 Estimated Milestone Bundle Amount: $567,458
TOTAL ESTIMATED DSRIP Funding for 4 Years *(add amounts of Estimated DSRIP Funding for years 2-5):* $3,094,979			

Project Option 1.9.1 – Expand Specialty Care Capacity: Recruiting targeted specialty care providers to RHP14

Unique Project ID: 136143806.1.5

Performing Provider Name/TPI: Midland Memorial Hospital / TPI: 136143806

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Memorial Hospital** is one of the three major hospitals in RHP14 and the only acute care hospital in Midland County-- estimated population of 144,500. MMH is a 320-bed not-for-profit acute care facility which provides inpatient and outpatient services to all the counties in RHP14. State data shows that approximately 25% of its inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery). Recruitment as always been an issue in west Texas. Leadership at MMH believes it is necessary and appropriate for the hospital to assume responsibility for recruiting providers.
Clearly state intervention(s)	The mean age of our medical staff is 49.4 and 23.3% of our medical staff are 60 or older. As our medical staff is aging we must recruit and retain at least one specialist into the region per year of the demonstration project.
Brief description of need for the project including appropriate data	RHP14 has a lower percentage of physicians that work directly with patients per population than the Texas average. Well-funded patients often travel outside the area for specialty care, leaving the uninsured and low income patient at a disadvantage. All counties in RHP14 have been designated as partial or total HPSA.
Target population – number of patients served – how Medicaid and/or indigent patients will benefit from project	Plans are to look at the prevalence of colorectal cancer screenings among our Hispanic population and work for higher utilization rates and greater penetration among this disparate group. Current estimate of Hispanic population (Nielsen, December 2012) is approximately 57,400 or 39.8% of Midland County's current population. Forty-four percent (44%) of patients with a diagnosis code of 578.1, blood in stool, were Hispanic, Latino/Spanish. Fifteen percent (15%) were Medicaid or uninsured patients.
Category 1 or 2 expected patient benefits	The expected increase in volume of services will be as follows DY3 – 220 patient encounters, DY4 – 1520 patient encounters, and DY 5 – 2820 patient encounters.
Category 3 outcomes	IT 11.1 – Improvement in Clinical Indicator in Identified Disparity Group – Increase colorectal cancer screening within the community's Hispanic population by a percentage to be developed in DY2 as part of this initiative.
CQI element(s)	N/A

- **Project Description:**

- Our goal is to increase the number of targeted specialty care providers in Midland by recruiting at least one (1) additional targeted specialist per year for the extent of the demonstration project thereby allowing Midland residents greater access to specialty health care. The expected increase in volume of services will be as follows DY3 – 220 patient

encounters, DY4 – 1520 patient encounters, and DY 5 – 2820 patient encounters. Our primary challenges include cost involved in recruitment; the competitive nature of recruiting the limited number of available physicians to a remote community; the need of providers to be bilingual in Spanish/English; and, with the energy-related economic boom, housing has become very limited. Funds from the DSRIP program will assist with the costs involved with recruitment of providers into our remote location. Formerly, short term grants from the Midland Development Corporation had funded a part of the recruitment of new physicians to area, but this has expired. We hope that the project funding will help with the expiration of this funding. In a secondary market, our community as a whole, has reacted to the lack of housing and is building new single dwelling homes, apartments and condominiums or is seeking other opportunities to increase available affordable housing.

Of the four core requirements listed for project 1.9.1, there is one that we are unable to complete since we are not an academic hospital with a residency program: "b-- increase the number of residents/trainees choosing targeted shortage specialties."

As part of our continuous quality improvement effort we will team with our public and media relations department to work on patient education within our targeted population. We will measure the impact of our project by examining whether we have increased the number of patients in our targeted population who are more engaged in their healthcare than they were before our intervention by monitoring their screening colonoscopy rate at our facility.

- **Starting Point/Baseline:**

We know from our Community Needs Assessment that the region has a lower percentage of physicians that work directly with patients per population than the state-wide average. To deal with this lack of specialty physicians, the region has relied on transfers of emergent patients out of the region, patients traveling to secure elective specialty care and a minimal number of satellite clinics (CN.6). Anecdotally, we believe the areas with the greatest need include gastroenterology, rheumatology, general surgery and orthopedics; however, confirmation of these assumptions will require completion of a current gap analysis

- **Rationale:**

Our Community Needs Assessment (Health Professional Shortage Areas, pp. 4-5) summarizes the rationale for this project well:

Texas ranks 42nd in the nation for the ratio of physicians to population and 47th for the ratio of nurses to population. There is a shortage of every kind of health professional in Texas except Licensed Vocational Nurses. Physicians, registered nurses, physical therapists, clinical laboratory scientists, occupational therapists, pharmacists, dentists, audiologists, and other health care professionals all number less (per 100,000 population) than the national averages (Dunkelberg, Anne. 2011. **Texas Health Care 2011: What Has Happened and the Work that Remains**, Center for Public Policy Priorities, 2011.) It is important for this RHP to build its healthcare workforce to (1) reduce the current shortage and (2) prepare for large increases in

demand as the population ages and more Texans become insured in 2014 through the Affordable Care Act. Midland County is a partial medically underserved area.

- **Related Category 3 Outcome Measure(s):**

  IT.11.1- Improvement in Clinical Indicator in identified disparity group — assuming that our anecdotal evidence is correct, one of the first targeted specialists will be a gastroenterologist. We are going to look at the prevalence of colorectal cancer screening among our Hispanic population and work for higher utilization rates and greater penetration among this disparate group.

- **Relationship to other Projects:**

  Similar to two of our other projects (1.6.2 – 68Nurse and 2.9.1 – EMS Patient Navigation System] we hope that increased access to specialty care will reduce non-emergent utilization of the ED.

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

- **Project Valuation**:

  The valuation of Midland Memorial's Expansion of Specialty Care project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project aims to improve access to care, quality of care and health outcomes by expanding the availability of healthcare providers in the region. This effort is designed to bring care to area residents who might not have access, particularly those who are uninsured, underinsured, or receive care through government programs. This will benefit the entire community by freeing up resources to provide additional care when needed and deliver care to those who might not otherwise seek it. Midland Memorial expects a good return on this investment because of the long-lasting benefit added by each additional provider.

136143806.1.5	***1.9.1***	***1.9.1 (A,C &D)***	***Expansion of Specialty Care Capacity***
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.5***	***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-1. Conduct specialty care gap assessment based on community need. By the September 30, 2013, a specialty gap analysis will be conducted to measure, assess, and target Specialty access needs for our community. Metric P-1.1. Documentation of gap analysis and assessment. Data Source P-1.1.a. Needs assessment Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,057,327	Milestone 2 I-22. Increase the number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. By September 30, 2014, hire or contract with at least one targeted specialty physician as identified in the gap analysis thereby increasing the additional available patient encounters in a specialist area by 220 over the base year (DY2). Metric I-22.1.a.b. Change in the number of specialist providers in targeted specialties / Number of specialist providers in targeted specialties at baseline Data Source I-22.1.c. Contract Milestone 2 Estimated Incentive Payment: $1,081,394	Milestone 3 I-22. Increase the number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. By September 30, 2015, hire or contract with at least one targeted specialty physician as identified in the gap analysis thereby increasing the additional available patient encounters in a specialist area by 1,520 over the base year (DY2). Metric I-22.1.a.b. Change in the number of specialist providers in targeted specialties / Number of specialist providers in targeted specialties at baseline Data Source I-22.1.c. Contract Milestone 3 Estimated Incentive Payment: $848,350	Milestone 4 I-22. Increase the number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. By September 30, 2016, hire or contract with at least one targeted specialty physician as identified in the gap analysis thereby increasing the additional available patient encounters in a specialist area by 2,820 over the base year (DY2). Metric I-22.1.a.b. Change in the number of specialist providers in targeted specialties / Number of specialist providers in targeted specialties at baseline Data Source I-22.1.c. Contract Milestone 4 Estimated Incentive Payment: $670,632
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,057,327	Year 3 Estimated Milestone Bundle Amount: $1,081,394	Year 4 Estimated Milestone Bundle Amount: $848,350	Year 5 Estimated Milestone Bundle Amount: $670,632
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,657,703			

Identifying Project and Provider Information:
EXPANSION OF BEHAVIOR HEALTH SCIENCES
1.9 Improve Access to Specialty Care/081939301.1.1
Project Option 1.9.2, Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:

- Provider: Texas Tech University Health Sciences Center of the Permian Basin is comprised of 50 providers and has clinics located in Ector County (approx. 900 square miles with a population of approx. 100,000), Midland County (approx. 900 square miles with a population of approx. 100,000) and Ward County (approx. 835 square miles with a population of approx. 7,000). In 2011 the population of RHP 14 was reported at 398,463 and is anticipated to increase to 424,968 by 2030. RHP 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. During FY11 TTUHSC provided services to 21,397 patients through 58,620 patient visits. Texas Tech University Health Sciences Center of the Permian Basin's Department of Psychiatry has one provider at this time.

- Intervention(s): This project will expand psychiatry services in Region 14 by adding additional providers as well as implementing telemedicine. We will introduce new ECT clinics and expand our referral base in order to increase patient access to care.

- Need for the project: Wait for enrollment for our psychiatry services is currently at 4 months in Midland County and 6 months in Ector County. We have patients traveling over three hours, one way, to access our services. The community needs assessment identified that between 2001 and 2010, the number of psychiatric hospitals in Texas increased by 5% and the number of bed increased by 8% while admissions for mental conditions increased by 22% across the state. Less than half the adult patients receiving referrals for specialty mental health services seek treatment while only one-fourth of children are treated in the community mental health system.

- Target population: The target population for this project is people who need psychiatric services. Target groups would include vulnerable segments of society such as women with postpartum depression and child and adolescents who show self-harming and suicidal tendencies. Approximately 63% of our patients are Medicaid, Medicare or unfunded patients who would benefit from increased access to care. In FY12 TTUHSC Psychiatry had approximately 2,000 visits. 40% of those patients were Medicaid, Medicare or unfunded. By hiring additional providers in DY 3 and DY4, and expanding

services offered we are expecting to see an increase over baseline of 25% in DY4 and an increase of 50% over baseline in DY5.

- Category 1 or 2 expected patient benefits:
  - Increased access to psychiatry services
  - Reduced wait and travel times
  - Development of outreach programs to identified at risk patient populations

- Category 3 outcomes: IT 2.4 – Our goal is to reduce behavioral health admissions by 5% in DY4 and DY5.

Project Description:

Texas Tech University Health Sciences Center (TTUHSC), Department of Psychiatry, has emerged as a significant source of psychiatric care for the uninsured and for the Medicaid and Medicare reimbursed clients. In recent years, with the increase in the population along with relocation of providers, the need for additional psychiatric services in our community has increased to a critical level. We have clients travelling more than three hours, one way, to access our psychiatric services. An average waiting time for enrollment to our services now stands at four months in Midland County and over six months in Ector County. Health and Human Services (HHS) has identified behavioral services as one of the priorities for the State of Texas. Hence the need for expansion of psychiatric services requires immediate attention. Psychiatric services are probably the most sought after services in school and nursing home settings. Lack of adequate access to psychiatric services is reflected in the recent increase in suicide rates in young population of Midland and Ector Counties in recent years. The situation is even more desperate in our adjoining 22 counties. The most vulnerable segments of our population and the ones most lacking in psychiatric services are children, women of reproductive ages and geriatric patients in the community and in nursing homes. The present psychiatric services provided through TTUHSC, Department of Psychiatry provides outpatient psychiatric services to both the above mentioned counties and to all segments of population along with consultation and liaison services to two local inpatient hospitals (Medical Center Hospital-MCH and Midland Memorial Hospital-MMH). At present we have no psychotherapeutic services for children and adolescents or clients with substance abuse concerns. In summary, recruitment of adequately trained psychiatrists is of critical need for our region based on the community needs assessment. This project will transform and increase access to care, foster regional collaboration and reduce Emergency Room (ER) visits and reduce in-patient admissions.

Provision of psychiatric services is a core health care need which is critically deficient in our region. It is a major public health care concern. Lack of adequate and timely clinical psychiatric care causes patients to seek emergency healthcare services. Such ER interventions cannot provide long term care and interventions needed for the majority of our clients. The practice of utilizing the ER for psychiatric services places an additional burden on our saturated ER system, deviating time and resources from other essential services. Excessive utilization of

ER services also increases the cost of healthcare and deteriorates quality of life satisfaction for our clients.

In order to accomplish improved access to psychiatric care and services in RHP 14, it is important that additional faculty physicians and staff be hired. Once additional physicians and staff are in place, increased access to specialty care and services will be developed through additional psychiatric clinics and the addition of telemedicine clinics which will have the potential to reach Midland, Odessa and our adjoining 22 counties.

Project Specifics:

- Expansion of **existing psychiatric services** so that over four years the average waiting time to obtain such services is less than one week,
- Availability of **increased psychiatric clinic services** in RHP14 and also potential availability of geriatric, child, forensic, psychosomatic psychiatric services to the population of West Texas in the next four years.
- Development and availability of **Tele-psychiatry services** to the West Texas region, including the adjoining 22 counties. Such services to be made available over four years to patients who at present need to travel more than 45 minutes one way to receive psychiatry services.
- Development and availability of **Electroconvulsive therapy (ECT) services** to indicated psychiatric patients.
- Increased **access and outreach** to vulnerable segments of society such as women with postpartum depression and child and adolescent who show self-harming and suicidal tendencies.

Starting Point/Baseline Data:

At this time one Psychiatrist and one Psychologist is available to patients through TTUHSC covering both Ector and Midland counties along with patients across 22 counties. Over the next four years two Psychiatrists, two psychologists and two social workers and associated staff will be hired thus increasing clinic capacity and access for psychiatric patients. The goal is to increase the number of psychiatric visits by 25% over baseline by the fourth year of project and to increase psychiatric visits additionally by the fifth year. Further the Department of Psychiatry will increase specialty care capacity with the utilization of telemedicine systems. We will establish liaisons with community clinics and schools to have access to child and adolescents at risk for self-harm. We will also assess the incidence and prevalence of postpartum depression through OB/GYN, primary care and other specialties. In FY12 TTUHSC Psychiatry had approximately 2,000 visits. 40% of those patients were Medicaid, Medicare or unfunded. By hiring additional providers in DY 3 and DY4, and expanding services offered we

are expecting to see an increase over baseline of 25% in DY4 and an increase of 50% over baseline in DY5.

Rationale:

It is important for Texas to build its healthcare workforce in order to 1) reduce the current shortages and 2) prepare for large increases in demand when more Texans become insured in 2014 through the Affordable Care Act, and 3) decrease inpatient behavioral health admissions. The total population of RHP 14 region grew by over 13% from 2000 to 2011. All but two counties (Ector and Midland) are considered rural by the 2010 U.S. Census. Only about 40% of people living in RHP 14 have commercial insurance. Twenty-nine percent are uninsured, and the remainder relies on Medicare, Medicaid, or CHIP. Texas ranks 42nd in the nation for the ratio of physicians to population and 47th for the ratio of nurses to population. There is a shortage of every kind of health professional in Texas. Physicians, registered nurses and other healthcare professionals all number less (per 100,000 populations) than the national averages. As of 2011, every county but three in RHP 14 is considered a Mental Health Professional Shortage Area. In Texas, between 2001 and 2010, the number of psychiatric hospitals increased by 5% and the number of beds increased by 8%. Admissions for mental health conditions increased by 22% across the state, indicating the growth in services may not meet the growth in need, for psychiatric services.

Unique Community Need Identification numbers the project address:

- CN-2: High costs associated with preventable hospitalization
- CN-3: Shortages of health care professionals
- CN-6: Need to overcome patient access to care barriers

Related Category 3 Outcome Measure(s):

- IT-2.4 Behavioral Health/Substance (BH/SA) Admission Rate (stand-alone measure)
- RHP 14 serves a large population of un-insured and under-insured individuals. Many of those patients do not have access to psychiatric services.
- Patients without psychiatric services utilize the ER disproportionately and thus strain the community health care resources including increases in hospital admissions. Access to Psychiatric care through increased clinical capacity and telemedicine should decrease hospital admissions for Behavioral Health and Substance Abuse while providing care to underserved populations. Early inventions in women with postpartum depression and in youths with suicidal and self-harming tendencies with improve morbidity and mortality besides improving the quality of life.

- ECT services will prove life saving for many with grave psychiatric illnesses such as depression and psychosis.

Relationship to other Projects:

The expansion of psychiatric services along with the establishment of tele-psychiatry will contribute to the peri-partum and post-partum psychiatric needs of the community. This will tie into project Option 1.1.1 INCREASE INFRASTRUCTURE DEDICATED TO HEALTHCARE FOR WOMEN which is expanding peri-partum and post-partum services to rural areas. Such expanded services will also help to meet psychiatric needs of the youth population and help reduce suicide rates and self-harming behaviors. With the introduction of ECT, the specific mental health needs of very sick individuals will be met locally **saving lives** and improving the **quality of life** of many of our clients. These will eventually reduce the overall morbidity and mortality along with cost of intervention by reducing ER visits and recurrent in-patient psychiatric admissions.

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

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

Wait for enrollment for our psychiatry services is currently at 4 months in Midland County and 6 months in Ector County. We have patients traveling over three hours, one way, to access our services. The community needs assessment identified that between 2001 and 2010, the number of psychiatric hospitals in Texas increased by 5% and the number of bed increased by 8% while admissions for mental conditions increased by 22% across the state. Less than half the adult patients receiving referrals for specialty mental health services seek treatment while only one-fourth of children are treated in the community mental health system.

081939301.1.1	***1.9 EXPAND SPECIALTY CARE CAPACITY***	***1.9.2 IMPROVE ACCESS TO SPECIALTY CARE***	***EXPANSION OF BEHAVIORAL HEALTH SCIENCES***
Texas Tech University Health Sciences Center of the Permian Basin			*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.1*	*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-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline/Goal: Establish Baseline Rate Data Source: IDX reports Milestone 1 Estimated Incentive Payment *:* $198,020 **Milestone 2** [P-X]: Complete planning and coordination of 1 new telemedicine systems Metric 1 [P-13.1]: Documentation of planning Data Source: Documentation of specialty system implementation plan Milestone 2 estimated incentive payment $198,020	**Milestone 5** [P-14]:Expand targeted specialty care (TSC) training Metric 1 [P-14.1]: Expand the TSC residency, mid-level provider(physician's assistant and nurse practitioners) and/or clinician/staff training programs and/or rotations Baseline/Goal: Hire 1 additional provider Data Source: HR documentation of hires Metric 2 [P-14.1]: Expand the TSC residency, mid-level provider (physician's assistant and nurse practitioners) and/or clinician/staff training programs and/or rotations Baseline/Goal: Hire additional staff	**Milestone 8** [P-14]: Expand targeted specialty care (TSC) training Metric 1 [P-14.1]: Expand the TSC residency, mid-level provider (physician's assistant and nurse practitioners) and/or clinician/staff training programs and/or rotations Baseline/Goal: Hire 1 additional provider Data Source: HR documentation of hires Metric 2 [P-14.1]: Expand the TSC residency, mid-level provider (physician's assistant and nurse practitioners) and/or clinician/staff training programs and/or rotations Baseline/Goal: Hire additional staff	**Milestone 11** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of visits Goal: 50% increased number of visits over baseline Baseline/goal: Baseline is expected to be based on FY12 number of 2,089 visits Data Source: EMR, IDX Milestone 11 Estimated incentive payment:$ 299,674 **Milestone 12** [I-33]: Increase specialty care capacity using innovative project option. Metric 1 [I-33.1]: Increase percentage of target population reached by mailing postcards to at risk teens

081939301.1.1	***1.9 EXPAND SPECIALTY CARE CAPACITY***	***1.9.2 IMPROVE ACCESS TO SPECIALTY CARE***	***EXPANSION OF BEHAVIORAL HEALTH SCIENCES***
Texas Tech University Health Sciences Center of the Permian Basin			*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.1*	*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 3 [P-13]: Complete planning and installation of new ECT (electroconvulsive therapy) system. Core Component A and B Metric 1 [P-13.1]: Documentation of planning and installation of new system Baseline/goal: Install new ECT machine Data Source: Documentation of specialty system implementation plan Milestone 3 estimated incentive payment $198,021 **Milestone 4**[P-11]: Launch/expand a specialty care clinic. Core component A and B Metric 1 [P-11-1]: Launch new ECT clinic Baseline/Goal: launching new ECT clinic	Data Source: HR documentation of hires Milestone 5 Estimated Incentive Payment: $289,935 **Milestone 6**[P-6]: Develop and implement standardized referral and work up guidelines. Core component C Metric 1 [P-6.1]: Develop liaisons with community schools and local hospitals for referrals Baseline/goal: develop referral systems from schools to clinics Data Source: referral and work up guidelines Milestone 6 Estimated Incentive Payment: $289,935 **Milestone 7**[P-11]: Launch/expand a specialty care clinic	Data Source: HR documentation of hires Milestone 8 Estimated Incentive Payment: $310,162 **Milestone 9**[I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of visits Goal: 5% increased number of visits over baseline. Baseline is TBD Data Source: EMR, IDX Milestone 9 Estimated incentive payment$310,163 **Milestone 10** [I-33]: Increase specialty care capacity using innovative project option. Metric 1 [I-33.1]: Increase percentage of target population reached by mailing postcards to at risk teens	Baseline/Goal: TBD% of target population reached by implementing post card mailings to at risk teens Data Source: documentation of mailings Milestone 12 Estimated incentive payment:$299,674 **Milestone 13** [P-21]: Participate in face-to-face learning (i.e meetings or seminars) at least twice per year with other provider 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. Metric 1 [P-21.1] Participate in semi-annual face to face meetings or seminars organized by the RHP

081939301.1.1	***1.9 EXPAND SPECIALTY CARE CAPACITY***	***1.9.2 IMPROVE ACCESS TO SPECIALTY CARE***	***EXPANSION OF BEHAVIORAL HEALTH SCIENCES***	
Texas Tech University Health Sciences Center of the Permian Basin				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.1*	*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)**
Data Source: provider schedules Milestone 4 Estimated Incentive Payment: $198,021	Metric 1:[P-11-1]: Launch 1 new telemedicine clinic Baseline/goal: 1 new telemedicine clinic Data Source: provider schedules Milestone 7 Estimated Incentive payment:$289,935		Baseline/Goal: TBD% of target population reached by implementing post card mailings to at risk teens Data Source: documentation of mailings Milestone 10 Estimated incentive payment:$310,163	Baseline/goal: to conduct quality improvement measures Data source: Meeting notes/brochures Milestone 13 incentive payment: $299,675
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $792,082	Year 3 Estimated Milestone Bundle Amount: $869,805		Year 4 Estimated Milestone Bundle Amount: $930,488	Year 5 Estimated Milestone Bundle Amount: $899,023
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,491,398				

Identifying Project and Provider Information:

V.I.P. RELATIONSHIPS IN THE PATIENT HOME: 081939301.1.2

1.1 Expand Existing Primary Care Capacity

Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:

Provider:

Texas Tech University Health Sciences Center of the Permian Basin is comprised of 50 providers and has clinics located in Ector County (approx 900 square miles with a population of approx 100,000), Midland County (approx 900 square miles with a population of approx 100,000) and Ward County (approx 835 square miles with a population of approx 7,000). In 2011 the population of RHP 14 was reported at 398,463 and is anticipated to increase to 424,968 by 2030. RHP 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. Texas Tech University Health Sciences Center of the Permian Basin (Odessa, TX), Department of Family and Community Medicine graduates six primary care physicians annually with eighteen resident and eight faculty physicians who provide care through 21,600 patient visits annually of which at least 63% have Medicaid, Medicare or are unfunded. During FY11 TTUHSC provided services to 21,397 patients through 58,620 patient visits.

Intervention:

The proposal will increase primary care physician access for underserved patients with highly rated patient satisfaction by: increased training of Family Medicine physicians; adopting outpatient efficiencies leading to patient centered medical home certification; and through development of a "Regional Network Relationship" database that identifies RHP 14 patients who underutilize and over utilize of health care services.

Need for Project:

Government funding and income from the practice of medicine support physician education and training. Seventy percent (70%) of our educational practice consists of underfunded patients thus hindering acquisition of resources for expanding the residency programs and supplying primary care physicians for the region. Furthermore, the model proposed here-in will train those physicians in care efficiencies and a patient-centered medical home model with a “Regional Network Relationship”.

Target Population:

The patient population of RHP 14 resides in underserved counties. According to the RHP 14 Community Needs Assessment, “69% of counties were relatively worse off than other Texas counties” and the report further identified that clinical care is a “major void”. Forty-five percent of RHP 14 patients are “uninsured or have Medicaid or CHIPS” according to the Community Needs Assessment.

In 2011 the population of RHP 14 was 398,463, but some areas of RHP 14 are currently some of the fastest growing cities in the nation. TTUHSC Permian Basin Family Medicine is striving to be the hub for building relationships between physicians and patients within RHP 14. In DY3 TTUHSC Family Medicine is implementing a patient registry. This registry will contain

patients whom the patient navigator will contact and manager care. In DY3 we will set the baseline for the patient registry. We are estimating this number to be 5,000 based on the FY12 patient counts. In FY12 TTUHSC Family Medicine had a total of 18,156 visits, with 67% of those being Medicare, Medicaid, or unfunded. At the Geriatric Center TTUHSC saw 2,290 visits with 92% of those being Medicare, Medicaid or unfunded. By the end of DY5 we are expecting to increase the number of patients reached by the patient navigator to be increased by 7% over baseline.

Category 1 and 2 expected patient benefits:

- Expand primary care training
- Implement patient registry/database
- Increase access to primary care capacity
- Establish a patient care coordinator position ("Boundary Spanner")
- Patient-centered Medical Home certification

Category 3 outcomes:

Ultimately effectiveness of this program is judged through patient satisfaction with his/her primary care provider relating to quality of care and access to care. We expect rising satisfaction levels over the term of the project.

Project Description:

Building relationships, the essence of Regional Healthcare Partnerships (RHP), the key to success of Southwest Airlines, and a model proposed for 21st century medicine, will transform healthcare through collaboration within RHP 14.[1,2] The RHP 14 Community Needs Assessment, July 2012, identified "clinical care" as a major void.[3] The report concluded, "there is great opportunity for improvement in clinical care, where about 69% of counties were relatively worse off than other Texas counties". Furthermore, family physicians provide 40% of care in RHP 14.[3] The logical "hub" for building relationships is, therefore, the Department of Family and Community Medicine at Texas Tech University Health Sciences Center of the Permian Basin (FM at TTUHSC-PB). Our departmental purpose, V.I.P. Relationships compel us to provide solutions for RHP 14 clinical care through relational coordination between the FM at TTUHSC-PB primary care "hub", regional patients, and regional physicians.

Family physicians provide the majority of healthcare in rural areas of the United States; resident graduates often practice near their rural training program; and physicians stay in rural areas when they feel supported.[3, 4, 5] Our residency program will appropriately train physicians for RHP 14 in a Patient Centered Medial Home (PCMH) model stressing relationships, and establishment of a Regional Network Relationship (RNR) of physicians and patients.
Our ongoing clinic renovation and repurposing of FM clinic space will form the foundation for sustainable growth of access to healthcare and expansion of the primary care workforce through addition of more faculty and resident physicians. The Accreditation Council for Graduate Medical Education (ACGME) requires resident physicians in Family Medicine to see 1,650 patients over three years. In addition to this increase in capacity locally, RHP 14 patients will have better access when FM at TTUHSC-PB graduates and places primary care physicians in the region. As of 2011, RHP 14 has a deficit of primary care physicians with a rate of 61 per

100,000 population (Texas overall rate is 69.5)as indicated in the needs assessment.[3] Placing these physicians regionally is a realistic goal and the only way to sustain physician supply into the future. Since 1984 FM at TTUHSC-PB has graduated 110 physicians of whom 48 remain in Texas and 29 practice medicine west of Abilene and south of Lubbock. This program growth adds to our proposal for developing a rural training track ("Family Medicine Rural Track Permian Basin" and presented by Dr. Charles Sponsel).

In order for graduating resident physicians to remain in rural areas requires a special subset of education, as well as support once in the rural region.[4] Family physicians capable of teaching obstetrical care are difficult to recruit to Odessa, Texas; therefore, we are training one of our own through local and regional collaboration. The Department's vision of providing obstetrical care and training resident physicians will occur in the FM at TTUHSC-PB clinic. Not only will our residents receive the proper skill-set, but they will train with the focus of VIP Relationships. Additionally they will be part of the Regional Network Relationship (RNR) project described below, and train in a PCMH with continuous process improvement.

Realizing that function is more than just physical space and adding physicians, we have developed ongoing self-study teams within our educational practice who are charged with redesign of primary care through continuous process improvement. These faculty and resident physician lead teams will incorporate administrative staff and nurses focusing on 1) Clinical Efficiency, 2) Clinical Communications, 3) Clinical Coding and Revenue, and 4) Clinical iPad Use.

Patient Centered Medical Home (PCMH) certification is an on-going process; however, the philosophy of PCMH (relationships) will be realized immediately through our self-study groups. Actual PCMH certification through the National Committee for Quality Assurance (NCQA) will take place in DY5. These groups will add availability by reducing clinic visit time ("cycle-time" - the time between arrival and dismissal from the clinic), without reducing patient satisfaction. Also, they will develop same or next day ("open access") appointments for patients contacted through the RNR and for patients calling after hours. As modeled at Southwest airlines, successful implementation will occur through development of a personnel position, called the patient navigator or boundary spanner. His/her job description will be implementation of the self-study group's ideas and will assist patient navigation through the healthcare system. Additionally, the physicians we train for RHP 14 will carry this model to their practice further providing access to care regionally, and they will have an established connection to the RNR.

Establishment of the RNR begins at the "hub" (FM-TTUHSC-PB) and with one RHP 14 county, with expansion to other counties to follow over the five year proposal. The purpose will be twofold: development of a database and relationships with regional patients and physicians. The database will consist of patients, identified in the Community Needs Assessment (CNA), who under-utilize primary care and over-utilize healthcare resources in the region.[3] According to the CNA, "the following groups were more likely than their counterparts to report that they could not access healthcare due to cost in the past 12 months: women, blacks and Hispanics, people younger than 65, those with no high school diploma, and people with low incomes. " Initially FM at TTUHSC-PB and Medical Center Hospital in Odessa, Texas electronic medical record systems will be queried to identify those patients with whom we already have a relationship. In the target counties of RHP 14 we will canvass the areas by going to local "hotspots" (schools, grocery stores, etc.) offering voluntary sign-up, develop relationships with local physicians to provide our networking services, and partner with Odessa cardiologists who already have clinic sessions in the outlying communities. Once the database is developed our

RNR will be coordinated by additional patient navigators or boundary spanners who will contact "high risk" (Table 1) patients via phone, a web-based patient portal or our already established telemedicine network, to monitor chronic disease and provide prevention. The patient navigators or boundary spanners will also be available for contact by those patients for other coordination of care (e.g. next day appointments).

People are the most valuable asset of any organization, and only with people can visions be obtained. Relationships with those people must then be established for success. This is the foundation of success at Southwest airlines and the vision and purpose of Family and Community Medicine at Texas Tech University Health Sciences Center of the Permian Basin.

Through the addition of faculty, residents and staff, FM-TTUHSC will enhance access to the RHP 14 population allowing them to receive the "right care at the right time in the right setting." At this time, FM-TTUHSC will not be expanding primary care clinic hours as the addition of providers will increase the patient's access to care significantly. Expansion of primary care clinic hours will be addressed at a later date as the need arises.

Project goals:

- Establishment of Regional Network Relationship with TTUHSC as the HUB
- Development of patient navigator position
- Patient centered medical home status
- Same day appointments
- Hire/train more primary care physicians

Through all of our goals we want to provide better access to care so that our patients can receive the right care, at the right time and in the right setting. By creating a patient centered medical home we hope to be the hub of all their medical care, thus reducing ER visits, hospital admissions and re-admissions. By developing one of our faculty members into a primary care with OB experience we will strive to revive the family physician of times passed, where you truly saw 1 physician for all your healthcare needs, and they even remembered your name.

Challenges and how we will address:

- Region 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. By creating the patient registry we will have a better system to track patients and to identify their needs. We will also be utilizing existing telemedicine systems to reduce travel time for patients.
- Letting the public know that we are here and the services that we provide. We will go to regional "hotspots" and let people know where we are and what we can do for them
- Recruitment of the Region 14 area. By increasing our resident compliment through this project we will be training physicians who will have a greater chance of staying in this area. Since 1984 FM at TTUHSC- PB has graduated 110 physicians of whom 48 remain in Texas, 29 practices west of Abilene and south of Lubbock.

Project relationship to regional goals:

By increasing our resident compliment and hiring additional faculty members TTUHSC will address the shortage of primary care physicians in the area. By creating the registry and hiring the patient navigator TTUHSC will be address the low utilization of preventative care.

TTUHSC will identify patients in registry that are over utilizers of the ED and under utilizers of preventative care and work with them (through the patient navigator) to correct this problem and ensure they are receiving the right care in the right setting.

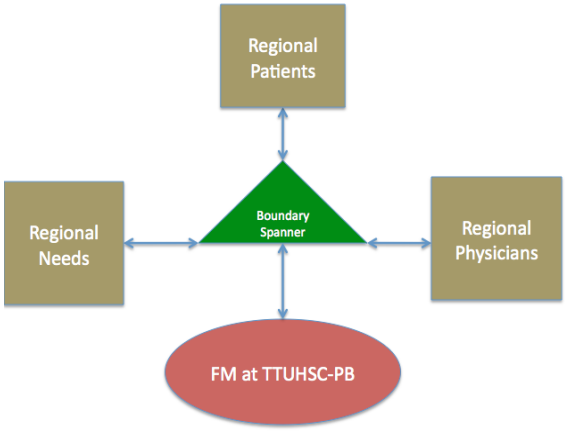
5 year expected outcome:

TTUHSC would like to achieve the patient centered medical home accreditation. We would like to have the open access concept available in the Family Medicine clinics. To have a considerable patient registry and have a patient navigator that follows these patients and helps them receive the care they need when they need it.

Starting Point/Baseline Data

In 2011 the population of RHP 14 was 398,463, but some areas of RHP 14 are currently some of the fastest growing cities in the nation. TTUHSC Permian Basin Family Medicine is striving to be the hub for building relationships between physicians and patients within RHP 14. In DY3 TTUHSC Family Medicine is implementing a patient registry. This registry will contain patients whom the patient navigator will contact and manager care. In DY3 we will set the baseline for the patient registry. We are estimating this number to be 5,000 based on the FY12 patient counts. In FY12 TTUHSC Family Medicine had a total of 18,156 visits, with 67% of those being Medicare, Medicaid, or unfunded. At the Geriatric Center TTUHSC saw 2,290 visits with 92% of those being Medicare, Medicaid or unfunded. By the end of DY5 we are expecting to increase the number of patients reached by the patient navigator to be increased by 7% over baseline.

Residency Program	FM at TTUHSC-PB Obstetrics Practice	RHP 14 Statistics	FM at TTUHSC-PB Payer Source
• 6 graduates / year • 110 graduates since 1984 • 21 west Texas graduates	• Prenatal care not offered	• Direct care providers: 50% counties below Texas 69.3/100,000 population ratio • 45% patient uninsured, Medicaid or CHIPS	• 70% self-pay, Medicaid, Medicare



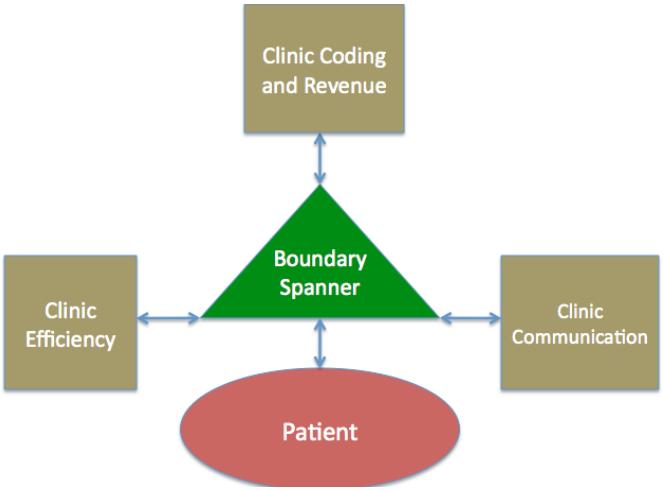


Figure 1: Regional Network Relationship

Figure 2: Reform Primary Care Practice

Rationale:

As of 2011, RHP 14 is experiencing a significant shortage of providers with a primary care physician rate of 61 per 100,000 population (Texas overall rate is 69.5). Expansion of Primary Care by placing physicians regionally is a realistic goal and the only way to sustain physician supply into the future. By expanding Primary Care and building improved relationships, patients will 1) receive more timely care, 2) have improved access to appointments and 3) experience increased levels of satisfaction with their overall medical care.

Unique community need identification numbers the project address:

- CN-3: Shortages of health care professionals, including primary care physicians and mental health care providers
- CN-5: Low utilization of preventative care services, especially by those

Related Category 3 Outcome Measure(s):

- IT-6.1 Percent improvement over baseline of patient satisfaction scores (stand-alone measure)
- RPH 14 counties continue to experience a significant physician shortage and according to the needs assessment, are worse off than other Texas counties. With family physicians providing 40% of care in RHP 14, it has become essential to expand primary care and improve patient satisfaction in the region.
- The Department of FM at TTUHSC-PB cares for a significant number of under-insured and un-insured patients within RHP 14. 70% of their patients have either Medicare or Medicaid or are self-pay. This population of patients, often times, does

not have access to quality medical care. The planned expansion of primary care capacity should lead to providing a medical home for many of these patients.

Relationship to other Projects:

This project supports and reinforces several other projects within the RHP 14 Plan listed below.

a. Family Medicine Rural Track Permian Basin (Category 1.2.4)

b. Diabetes Coordinated Care Center (Category 2.2.1)

c. New Model of Diabetes Care in the Outpatient Clinic (2.3.1)

Coordination of Patient Care utilizing the projects above will lead to a percent improvement over baseline patient satisfaction scores.

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

As of 2011, RHP 14 is experiencing a significant shortage of providers with a primary care physician rate of 61 per 100,000 population (Texas overall rate is 69.5). Expansion of Primary Care by placing physicians regionally is a realistic goal and the only way to sustain physician supply into the future. By expanding Primary Care and building improved relationships, patients will 1) receive more timely care, 2) have improved access to appointments and 3) experience increased levels of satisfaction with their overall medical care.

References:

1. Gittel, Jody. The Southwest Airlines Way: Using the Power of Relationships to Achieve High Performance. McGraw- Hill, 2003.

2. Roter D. The enduring and evolving nature of the patient-physician relationship. Patient Education and Counseling. 2000; 39:5-15.

3. Regional Healthcare Partnership Region 14 Community Needs Assessment, July 2012.

4. "Rural practice, keeping physicians in (Position Paper). AAFP, 2009. Available at: http://www.aafp.org/online/en/home/policy/policies/r/ruralpracticekeep.html.

5. Rosenthal TC, McGuigan MH, and Anderson G. Rural residency tracks in Family Practice: graduate outcomes. Fam Med 2000;32(3):174-7.

081939301.1.2	***1.1 EXPAND PRIMARY CARE CAPACITY***	***1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY***	***VIP RELATIONSHIPS IN THE PATIENT HOME***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcomes	*081939301.3.2*	*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-X]: Expand primary care training* Metric 1 [P-X.1]: Obtain approval from ACGME to expand residency program Baseline/Goal: Expand resident compliment one (1) resident in DY4 and DY5 Data Source: Documents from ACGME showing approval Milestone 1 Estimated Incentive Payment *(maximum amount):* $154,973 **Milestone 2** [P-1]: Relocate primary care clinics Metric 1 [P-1.1]: Reallocate space for Primary Care Clinic – space repurposing and renovation Baseline/Goal: Increase Family Medicine clinics by repurposing/renovating space Data Source: Documentation of renovation plans	**Milestone 6** [P-5]: Train/hire additional primary care staff Metric 1 [P-5.1]: Hire 1 family medicine faculty Baseline/Goal: Hire 1 family medicine faculty member Data Source: HR Documentation Milestone 6 Estimated Incentive Payment: $283,632 **Milestone 7** [P-X]: Implement patient registry Metric 1: Implement patient registry Baseline/goal: Enroll 200 patients in registry Data source: Patient registry Milestone 7 estimated incentive payment:$ 283,632 **Milestone 8**[P-X]: Establish baseline rates Metric 1[P-X.1]: Establish baseline rates		**Milestone 9** [P-5]: Train/hire additional primary care providers Metric 1[P-5.1]: Match and hire the increased compliment of residents approved in DY2 Baseline/Goal: match and hire one (1) additional first year resident Data Source: HR documentation Milestone 9 Estimated Incentive Payment:$303,420 **Milestone 10** [I-15]: Increased access to primary care capacity Metric 1 [I-1.15.1]: Increase % of target population reached Goal: Increase target patient population reached by 5% over baseline Data Source: documentation of population reached Milestone 10 Estimated Incentive payment: $303,420	**Milestone 12** [P-5]: Train/hire additional primary care providers Metric 1[P-5.1]: Match and hire the increased compliment of residents approved in DY2 Baseline/Goal: match and hire one (1) additional first year resident Data Source: HR documentation Milestone 12 Estimated Incentive Payment:$293,159 **Milestone 13** [I-15]: Increased access to primary care capacity Metric 1 [I-1.15.1]: Increase % of target population reached Goal: Increase target patient population reached by 7% over baseline Data Source: documentation of population reached Milestone 13 Estimated Incentive payment: $293,159

081939301.1.2	***1.1 EXPAND PRIMARY CARE CAPACITY***	***1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY***	***VIP RELATIONSHIPS IN THE PATIENT HOME***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcomes	*081939301.3.2*	*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 2 estimated incentive payment:$ $154,973 **Milestone 3** [P-X]: Develop/create a patient registry Metric 1: Create registry for patient care management Baseline/goal: Create patient registry Data source: Documentation of registry creation Milestone 3 estimated incentive payment:$ $154,973 **Milestone 4** [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of project Metric 1[P-X.1]: Complete a strategic plan for implementation Baseline/goal: Development of strategic plan Data source: documentation of	Baseline/goal: Establish baseline rates Data source: Patient Registry in DY3. Number is estimated to be 5,000 based on FY12 patient counts. Milestone 8 estimated incentive payments:$ 283,631		**Milestone 11**[P-X]: Assess efficacy of processes in place and recommend process improvements to implement, if any Metric 1: To evaluate processes and determine in process is effective and if milestones are being met Baseline/goal: To evaluate processes and determine effectiveness Data source: Evaluation Records Milestone 11 Estimated Incentive payment:$ 303,420	**Milestone 14** [I-X]: Obtain medical home recognition by a nationally recognized agency Metric 1[I-X.1] Medical home recognition/accreditation Baseline/goal: obtain accreditation from NCQA Data source: Documentation showing accreditation Milestone 14 estimated incentive payment:$ 293,160

081939301.1.2	***1.1 EXPAND PRIMARY CARE CAPACITY***	***1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY***	***VIP RELATIONSHIPS IN THE PATIENT HOME***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcomes	*081939301.3.2*	*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)**
strategic plan Milestone 4 estimated incentive payment:$ $154,972 **Milestone 5**[P-X]: Hire patient navigator Metric1 Hire 1 patient navigator /boundary spanner Goal: hire 1 patient navigator/boundary spanner position Data source: HR documentation Milestone 5 Estimated Incentive payment:$ $154,972				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $774,863	Year 3 Estimated Milestone Bundle Amount: $ 850,895		Year 4 Estimated Milestone Bundle Amount: $910,260	Year 5 Estimated Milestone Bundle Amount: $879,478
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,415,496				

Identifying Project and Provider Information:
Family Medicine Rural Track 081939301.1.3
1.2 Increase Training of Primary Care Workforce
Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:

- **Provider:** Texas Tech University Health Sciences Center of the Permian Basin is comprised of 50 providers and has clinics located in Ector County (approx 900 square miles with a population of approx 100,000), Midland County (approx 900 square miles with a population of approx 100,000) and Ward County (approx 835 square miles with a population of approx 7,000). In 2011 the population of RHP 14 was reported at 398,463 and is anticipated to increase to 424,968 by 2030. RHP 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. During FY11 TTUHSC provided services to 21,397 patients through 58,620 patient visits. In this project TTUHSC is looking to partner with Big bend Regional Medical Center which is a 25 bed hospital in Alpine TX, serving a three county 12,308 square mile area with a population of approximately 20,000 (2011). In 2008 there was an estimated population of 9,200 with almost 50% of those being without insurance. Brewster County is also considered a low income county according to the CNA. We are also looking to partner with Pecos County Memorial Hospital in Fort Stockton TX. It is a 37 bed hospital serving a population of approximately 16,000 (2011). In 2009 there was an estimated population of 16,000 with over 50% of them being without insurance.

- **Intervention:** This project will train two Family Medicine physicians per year with a rural specialty.

- **Need for the project:** To increase the number of primary care providers to rural west Texas. Texas primary care is in critical condition with rural physician shortages throughout Regional Healthcare Partnership 14 (RHP 14). This shortage is exacerbated by the fact that the Texas population is growing faster than almost any other state in the U.S. The number of caregivers is not keeping pace with the growth rate, and the Affordable Care Act will potentially expand the patient base by an estimated 5 million currently uninsured Texans starting in 2014. The goal for this project is to help reduce the shortage of primary care physicians in rural West Texas which will better accommodate the needs of the patient population and local communities.
    - These increased numbers of Resident Physicians will see unfunded, Medicaid, and Medicare patients in these rural regions as well as provide medical support to clinics in Marfa and Presidio Texas.
    - It is shown that extended learning experiences in rural tracts are likely to create an increase in primary care physicians in the rural communities.

- **Target Population:** The target population is those patients who are unfunded, or have Medicaid/Medicare as their pay source. In this project TTUHSC is looking to partner with Big bend Regional Medical Center which is a 25 bed hospital in Alpine TX, serving a three

county 12,308 square mile area with a population of approximately 20,000 (2011). In 2008 there was an estimated population of 9,200 with almost 50% of those being without insurance. Brewster County is also considered a low income county according to the CNA. We are also looking to partner with Pecos County Memorial Hospital in Fort Stockton TX. It is a 37 bed hospital serving a population of approximately 16,000 (2011). In 2009 there was an estimated population of 16,000 with over 50% of them being without insurance.

- **Category 1 or 2 expected patient benefits**
  - An expansion of the primary care base in rural west Texas
  - Increased education in chronic diseases (i.e.; DM, CHF, COPD, CAD, HTN, Obesity)
  - Decrease in complications from chronic diseases
  - Increase in collaboration between the rural west Texas areas and Texas Tech University Health Sciences Center and MCH Odessa
  - Decreased hospital admissions and readmissions secondary to above

- **Category 3 outcome** Decrease ED visits by a TBD% by DY5

Project Description:

Texas primary care is in critical condition with rural physician shortages throughout Regional Healthcare Partnership 14 (RHP 14). This shortage is exacerbated by the fact that the Texas population is growing faster than almost any other state in the U.S. The number of caregivers is not keeping pace with the growth rate, and the Affordable Care Act will potentially expand the patient base by an estimated 5 million currently uninsured Texans starting in 2014. Additional factors adding to the physician shortage include the increasing need of the senior patient population, older doctors looking toward retirement, and a declining number of medical students choosing primary care. This situation cannot continue to be ignored. The goal for this project is to help reduce the shortage of primary care physicians in rural West Texas which will better accommodate the needs of the patient population and local communities.

In 2008 the American Academy of Family Physicians (AAFP) and the National Rural Health Association (NRHA) stated that, despite 30 years of policy initiatives and incentives, the number of physicians in rural areas remains insufficient for the needs of the rural communities. It is shown that extended learning experiences in rural tracts are likely to create an increase in primary care physicians in the rural communities. This expansion of the primary care base would improve access to care, decrease emergency department visits, and decrease hospital admissions by improving patient education and increasing collaboration between the rural community physicians and Medical Center Hospital. Currently RHP 14 has 11 out of 14 counties that are designated as a medical underserved area by the Health Resources and Services Administration (HRSA).

The Texas Tech Family Medicine Rural Track-Permian Basin (TTFMRT-PB) will be developed by the Texas Tech University Health Sciences Center Family and Community Medicine Department at the Permian Basin and submitted for approval by the ACGME during the first year of the project. Recruitment of two (2) Family Medicine Residents and appropriate Faculty will occur in year 2. Rural Clinic assessment, IT support, and the development of Telemedicine between Alpine, Texas and Ft. Stockton, Texas (RHP 13) (Pecos County) and

TTUSHC-SOM Permian Basin will also occur. Year 3 will be the initial year of training for 2 (two) residents at Medical Center Hospital Odessa. Starting year 4, residents completing their 1st year at MCH will begin their rural training in Alpine, TX at Big Bend Regional Medical Center (BBRMC) and Ft. Stockton, TX at Pecos County Memorial Hospital, RHP 13 (PCMH). One resident will be assigned to each rural community. Two new residents will begin their 1st year at MCH Odessa. Year 5 will follow with 2 residents doing their 1st year residency at MCH Odessa and progressing each year to their assigned rural destinations.

At the conclusion of the 5th year, two FM Rural Specialty Trained Residents will graduate. There will also be two residents in each year of the TTFMRT-PB, a 3 year program. This advancement and graduation of Rural Trained Family Medicine Physicians will continue on an annual basis.

These increased numbers of Resident Physicians will see unfunded, Medicaid, and Medicare patients in these rural regions as well as provide medical support to clinics in Marfa and Presidio Texas.

Specific challenges which may be encountered during the development of this program can include the recruitment of Residents and Faculty to West Texas, the availability of medical staffing in the rural areas, and a large unfunded population in RHP 14.

Project Specifics:

The expected outcomes at the conclusion of this project will be:

- Train two (2) residents per year in the Rural Tract.
- Graduate two (2) Family Medicine Physicians with extensive Rural Training per year.
- Increase the number of Rural Residency Training Programs nationwide. Currently there are only twenty-four (24) Family Medicine Rural Training Tracks in 17 different states. (traindocsrural.org)
- Increase the number of Residents, Medical Students, Faculty, and Medical Staff involved in rural care.
- Expansion of the primary care base in (RHP 14)
- Increased education in chronic diseases (i.e. DM, CHF, COPD, CAD, HTN, Obesity)
- Decrease in complications from chronic diseases.
- Increase collaboration between the rural communities in RHP 14 and RHP 13 (Pecos County) with Texas Tech University Health Sciences Center and MCH Odessa.
- Improvement in perinatal outcomes.
- Decreased ED visits secondary to the above.

- Decreased Hospital admissions and readmissions secondary to the above.

Starting Point/Baseline Data

Currently Texas Tech University Health Sciences Center-Permian Basin does not train residents dedicated to rural medical care. It will necessary to request approval from the ACGME to increase the number of primary care residents in the Department of Family and Community Medicine and in turn recruit and hire additional faculty for the purpose of training residents.

Rationale:

This project/intervention along with its corresponding milestones and metrics is a response to RHP's need for increased primary care physicians. The 1-2 rural track programs has been shown successful with 76% of its graduating residents favoring a rural practice. So, improved medical care in the West Texas rural areas will result with an increase in patient education, a decrease in chronic disease complications and fewer hospitalizations.

Unique community need identification number the project addresses:

- CN-1: High rates of chronic disease
- CN-2: High costs associated with preventable hospitalization
- CN-3: Shortages of health care professionals
- CN-5: Low utilization of preventative care services
- CN-6: Need to overcome patient access to care barriers

Related Category 3 Outcome Measure(s):

- IT-9.2 ED appropriate utilization (stand-alone measure)

The establishment of a Family Medicine Training Program in the Health Care Provider Shortage Areas (HPSA) within RHP 14 will increase the number of primary care providers in the area. The TTFMRT-PB will provide increased medical access to the unfunded, Medicaid, and Medicare patients in the area. This increased medical access will improve patient education of chronic disease management which will result in a decrease of ED utilization.

Relationship to other Projects:

This project supports and reinforces several other projects within the RHP 14 plan listed below.

a. V.I.P. Relationships in the Patient Home (1.1.2)

b. Diabetes Coordinated Care Center (2.2.2)

c. New Model of Diabetes Care in the Outpatient Clinic (2.3.1)

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

In this project TTUHSC is looking to partner with Big bend Regional Medical Center which is a 25 bed hospital in Alpine TX, serving a three county 12,308 square mile area with a population of approximately 20,000 (2011). We are also looking to partner with Pecos County Memorial Hospital in Fort Stockton TX. It is a 37 bed hospital serving a population of approximately 16,000 (2011). Every person living in these counties could potentially be impacted and receive great value from an increase in access to primary care in their county.

081939301.1.3	***1.2***	***1.2.4***	***FAMILY MEDICINE RURAL TRACK***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.3*	*IT 9.2*	*ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development Metric 1[P-X.1]: Develop program curriculum Baseline/goal: Develop program curriculum Data Source: Program curriculum documentation Metric 2[P-X.1]: Engage stakeholders Baseline/goal: engage stakeholders Data source: documentation showing correspondence with stakeholders Metric 3[P-X.1]: Identify resources needed Baseline/goal: Identify resources needed to implement project Data source: documentation showing resources needed	**Milestone 4** [P-10]: Obtain approval from the ACGME to increase the number of primary care residents Metric 1 [*P-10.1*]: Documentation of ACGME approval for residency position expansion Baseline/Goal: Receive approval from ACGME for two (2) additional first year residents to be added in DY3, DY4 and DY5 Data Source: approved application from ACGME Milestone 4 Estimated Incentive Payment *(maximum amount):* $255,268 **Milestone 5** [P-X]: Recruit and match two (2) first year residents Metric 1 [P-X.1]: Recruit and match two (2) first year residents Baseline/Goal: Match 2 first year residents Data Source: HR documentation		**Milestone 8**[P-2]: Expand primary care training for primary care providers Metric 1 [P-2.2]: Hire additional precepting primary care faculty members Baseline/Goal: Hire two (2) family medicine faculty Data Source: HR documents Milestone 8 Estimated Incentive Payment: $273,078 **Milestone 9**[P-X]: Recruit and match two (2) first year residents Metric 1 [P-X.1]: Recruit and match two first year residents Baseline/Goal: Match 2 first year residents Data Source: HR documentation Milestone 9 Estimated Incentive Payment: $273,078 **Milestone 10** [P-2]: Expand primary	**Milestone 12**[P-X]: Recruit and match two (2) first year residents Metric 1 [P-X.1]: Recruit and match two (2) first year residents Baseline/Goal: Match 2 first year residents Data Source: HR documentation Milestone 12 Estimated Incentive Payment: $527,687 **Milestone 13** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees as measured by percent change of class size over baseline or by absolute number Baseline/goal: Increase number of family medicine residents by two over baseline of class size in DY2 Data source: program enrollment records

081939301.1.3	***1.2***	***1.2.4***	***FAMILY MEDICINE RURAL TRACK***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.3*	*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 estimated incentive payment:$309,945 **Milestone 2** [P-2]: Expand primary care training for primary care providers Metric 1 [P-2.3] develop alternative primary care training modalities Baseline/goal: develop plan to have telemedicine available to rural sites in DY3 Data source: Implementation plan Milestone 2 estimated incentive payment:$309,945 **Milestone 3**[P-2]: Expand primary care training for primary care providers Metric 1 [P-2.2]: Hire additional precepting primary care faculty members Baseline/Goal: Hire two (2) .5 FTE family medicine faculty Data Source: HR documents	Milestone 5 Estimated Incentive Payment: $255,268 **Milestone 6** [P-2]: Expand primary care training for primary care providers Metric 1 [P-2.3]: develop alternative primary care training modalities Baseline/goal: 1 telemedicine equipment installed in Alpine TX Data source: documentation showing installed machine Milestone 6 estimated incentive payment:$ 255,269 **Milestone 7**[P-6]: Develop/expand enrollment in programs that provide primary care training that lead to retain the graduates and commit to serve in specific communities, e.g. HPSA Metric 1 [P-6.1]: Provide training for commitment to serve in specific communities Baseline/goal: Training residents in rural communities to better serve HPSA areas		care training for primary care providers Metric 1 [P-2.3]: develop alternative primary care training modalities Baseline/goal: 1 telemedicine equipment installed in Fort Stockton TX Data source: documentation showing installed machine Milestone 10 estimated incentive payment: $273,078 **Milestone 11** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees as measured by percent change of class size over baseline or by absolute number Baseline/goal: Increase number of family medicine residents by two over baseline of class size in DY2 Data source: program enrollment records Milestone 11 estimated incentive	Milestone 13 estimated incentive payment:$ 527,687

081939301.1.3	***1.2***	***1.2.4***	***FAMILY MEDICINE RURAL TRACK***
Texas Tech University Health Sciences Center			*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.3*	*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 3 Estimated Incentive Payment:$309,945	Data source: contractual agreements with rural hospital(s) Milestone 7 estimated incentive payment:$ 255,269	payment: $273,078	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $929,835	Year 3 Estimated Milestone Bundle Amount: $1,021,074	Year 4 Estimated Milestone Bundle Amount: $1,092,312	Year 5 Estimated Milestone Bundle Amount: $1,055,374
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,098,595			

Identifying Project and Provider Information:

INCREASE INFRASTRUCTURE DEDICATED TO HEALTHCARE FOR WOMEN 081939301.1.4

1.1 Expand Existing Primary Care Capacity

Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:

- **Provider:** Texas Tech University Health Sciences Center at the Permian Basin (TTUHSC-PB) is a regional campus of Texas Tech University Health Sciences Center. TTUHSC-PB serves a broad geographic of RHP 14. During FY 2011 TTUHSC provided services to 21,397 patients through 58,620 patient visits.

- **Intervention(s):**
  - Increase infrastructure and staffing with geographic expansion to underserved areas.
  - Identify regional gaps and barriers to adequate healthcare to redesign care to address those issues found.
  - Provide timely, quality prenatal care

- **Need for the project:** The Permian Basin population is almost 30% uninsured, with women 1.5 times more likely to have no health insurance. Barriers to access cause significant gaps in the provision of adequate and timely healthcare. These barriers may include language differences, transportation and lack of awareness of available services in addition to financial concerns. Due to these barriers prenatal care often begins late in the third trimester, if at all. Gynecological cancer diagnosis occurs in later stages. Debilitating conditions with simple and inexpensive treatments go untreated. Barriers must first be identified the programming targeted to address these impediments to adequate women's' healthcare in the region

- **Target population:** Women within the region who currently have inadequate access to health care. TTUHSC-PB provides care for a significant number of under-insured or un-insured patients within RHP 14. 70% of patients are Medicaid, Medicare or self-pay. Gynecology specialty care is often not covered by state-run programs. The project will target these underserved populations. In 2010, when TTUHSC operated the rural clinics in Monahans, Kermit, McCamey and Stanton 2,726 visits occurred with a total of 79% being Medicare, Medicaid or unfunded. In 2010 approximately 350 visits occurred in McCamey, this will be used as the baseline for milestone improvements. We are expecting a 40% increase in DY 4 over baseline and a 60% increase over baseline for DY5.

- **Category 1 or 2 expected patient benefits:**
  - Increase in number of women in region with access to coverage for obstetrical and gynecologic care.
  - Improvement in perinatal outcomes
  - Improvement women's health indices such as reduction in sexually transmitted disease rates and increased cervical and breast cancer screening rates.

- Improved quality of life and productivity for Texas women.
- Reduced overall health care costs due to timely, prevention-oriented care.

- **Category 3 outcome-related patient benefits:**
  - Increased breast and cervical cancer screening
  - Increased colorectal cancer screening
  - Decrease in Teen Pregnancy
  - RPH 14 counties continue to experience a significant physician shortage and according to the needs assessment, are worse off than other Texas counties making it essential to expand into adjoining rural communities. Process milestones toward increasing capacity include stakeholder identification and assembly, analysis of current capacity and baseline data-gathering. Intervention planning is also part of the DY2/DY3 phase and includes strategic planning,
  - The primary interventional goal of the project is an increase in access to primary and preventative care from women in RPF 14 though through TTUHSC-PB. Data supporting the utility of this intervention in the regional population include the Community Needs Assessment showing 40% failure to receive early, first trimester prenatal care. Also, the intervention targets high teen pregnancy rates and STD rates in Ector County. The rationale for the project rests on improving access to care for low income women who are 1.5 times as likely as men to be uninsured in a state with the highest uninsured population in the county. The lack of coverage affects ability to access screening for cervical cancer.

Project Description:

According to the Community Needs Assessment, Texas has the highest population of uninsured at 26%. More than a quarter of Texas women also remain uninsured, numbers widely known to be underestimated due to the large population of undocumented residents in the state. Women in Texas, therefore experience difficulty obtaining basic obstetric and gynecological services such as prenatal care, family planning, annual PAP and mammographic screening. There is also reduced access to specialized care for women such as surgery and cancer treatment related to gynecologic diagnoses. RHP 14 uninsured numbers approach 30% and women in the region are more likely than men to have no healthcare coverage. While there are specialized programs created to address women's healthcare for the under and uninsured (title programs, The Women's Health Program, etc.) there remain barriers to access causing significant gaps in the provision of adequate and timely healthcare to women in the state of Texas. As a consequence, prenatal care visits often begin late in the third trimester, if at all. Diagnoses of gynecologic cancers oftentimes occur late in the illness with treatment-resistant stages leading to increased morbidity and decreased patient survival. Debilitating conditions such as urinary incontinence with fairly simple and inexpensive treatment options go untreated.

The Texas Tech Health Sciences Center-Permian Basin (TTUHSC-PB), Department of Obstetrics and Gynecology as part of the RHP 14 proposes to address regional gaps in women's access to healthcare through the increase of infrastructure dedicated to provision of healthcare for women in the Permian Basin through increased staffing, geographic expansion of obstetric

and gynecologic care within the region and collaboration with community agencies and providers.

Project Specifics

- Increased staffing and geographic expansion (establishment of rural clinics) of Obstetrics and gynecologic are within the region
- Collaboration with community agencies and providers
- Increase numbers of patients served by TTUHSC receiving early prenatal care and annual screening services and gynecologic surgeries.

Starting Point/Baseline Data

Currently TTUHSC-PB Department of Obstetrics and Gynecology serves an average of 30,000 patients per annum. Over the past year (2011) obstetric and gynecologic services have included an estimated 1,200 vaginal and cesarean deliveries, 300 gynecologic surgeries in hospital and 10,000 outpatient encounters. Expansion into rural communities has only recently been instituted in 2012 on a limited basis in Ward County. Enrollment in women's health care assistance programs is relatively low compared to percent eligible. Additionally, the percent of patients with no coverage is high. In 2010, when TTUHSC operated the rural clinics in Monahans, Kermit, McCamey and Stanton 2,726 visits occurred with a total of 79% being Medicare, Medicaid or unfunded. In 2010 approximately 350 visits occurred in McCamey, this will be used as the baseline for milestone improvements. We are expecting a 40% increase in DY 4 over baseline and a 60% increase over baseline for DY5.

Rationale:

This project is a primary care capacity –building intervention focusing on primary healthcare for women. Project selection is in direct response to the Community Needs Assessment for RFP 14 indicating high uninsured rates among women at 30%. 40% of women in RFP 14 do not receive prenatal care in the first trimester. Many women cannot afford gynecologic care which would restore them to health and productivity. The expected outcomes of the project cut across multiple milestone and improvement targets in the RHP 14 design as primary care for women involves multiple facets including obstetric and gynecologic care as well as screening. The project also requires an ecological determinant type approach to problem solving when choosing milestones and metrics as it encompasses healthcare disparity issues unique to rural women. However, these goals must be taken as a whole for women have a range of primary health needs across the spectrum of life. This project outlines clearly definable process and improvement steps such as completed strategic planning acquiring facilities where patient visits can be conducted in outlying rural communities and numbers of providers hired to staff those facilities. It follows that metrics should include increased numbers of women having access to healthcare, thus allowing them to receive "the right care at the right time in the right setting"

Unique community needs identification numbers the project address:

- CN-1: High Rates of Chronic Disease including obesity and diabetes which negatively impact pregnancy
- CN-3: Shortages of health care professionals particularly in Region 14 rural catchment areas
- CN-5: Low utilization of preventative care services most specifically breast and cervical cancer screening, STD and adolescent pregnancy prevention
- CN-6: Need to overcome patient access to care barriers including, financial, informational, literacy, language, and transportation impediments.
- CN-7: Need for improvement in prenatal and perinatal care with respect to access, utilization and comprehensiveness of care.
- CN-11: High rate of teen pregnancy

Related Category 3 Outcome Measure(s):

- IT-12.2 Cervical Cancer Screening (Non-standalone measure)
- IT-12.3 Colorectal Cancer Screening (Non-standalone measure)
- IT-12.5 Other USPSTF-Decrease in Teen Pregnancy
- RPH 14 counties continue to experience a significant physician shortage and according to the needs assessment, are worse off than other Texas counties making it essential to expand into adjoining rural communities. Process milestones toward increasing capacity include stakeholder identification and assembly, analysis of current capacity and baseline data-gathering. Intervention planning is also part of the DY2/DY3 phase and includes strategic planning,
- The primary interventional goal of the project is an increase in access to primary and preventative care from women in RPF 14 though through TTUHSC-PB. Data supporting the utility of this intervention in the regional population include the Community Needs Assessment showing 40% failure to receive early, first trimester prenatal care. Also, the intervention targets high teen pregnancy rates and STD rates in Ector County. The rationale for the project rests on improving access to care for low income women who are 1.5 times as likely as men to be uninsured in a state with the highest uninsured population in the county. The lack of coverage affects ability to access screening for cervical cancer.

Relationship to Other Projects:

This project supports and reinforces several other projects within the RHP 14 Plan listed below.

d. Implement Evidence Based Health Promotion Programs (2.6.1)

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

References:

6. Regional Healthcare Partnership Region 14 Community Needs Assessment, July 2012.

081939301.1.4	***1.1.1 ESTABLISH MORE PRIMARY CARE CLINICS***	***1.1.1***	***INCREASE INFRASTRUCTURE DEDICATED TO HEALTHCARE FOR WOMEN***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.4* *081939301.3.5* *081939301.3.6*	*IT 12.1* *IT 12.2* *IT 12.5*	*Breast Cancer Screening* *Cervical Cancer Screening* *Second Teen Pregnancy 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-X] Strategic expansion planning complete Metric 1 [*P-X.1*]: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan Data Source: Completed strategic expansion plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $370,212 **Milestone 2** [P-5]: Train/hire additional primary care providers and/or staff Metric 1 [P-5.1]: hire a project coordinator position Baseline/goal: To hire 1 administrative project coordinator Data source: HR documentation Milestone 2 Estimated Incentive payment:$370,212	**Milestone 3** [P-1]:Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Facilities acquired for regional clinic Baseline/Goal: acquire facilities for regional clinic site 1 Data Source: documents showing acquisition of space Milestone 3 Estimated Incentive Payment: $271,026 **Milestone 4** [P-5]: Train/hire additional primary care providers and/or staff Metric 1 [P-5.1]:Train/hire staffing needed for regional clinic 1 Baseline/Goal: hire staff needed for regional clinic 1 Data Source: HR documentation Milestone 4 Estimated Incentive Payment: $271,026		**Milestone 6** [P-1]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Facilities acquired for regional clinic Goal: acquire facilities for regional clinic site 2 Data Source: documents showing acquisition of space Milestone 6 Estimated Incentive Payment: $289,935 **Milestone 7** [P-5]: Train/hire additional primary care providers and/or staff Metric 1 [P-5.1]: train/hire staffing needed for regional clinic site 2 Goal: hire staff needed for regional clinic site 2 Data Source: HR documentation Milestone 7 Estimated Incentive Payment: $289,935 **Milestone 8** [I-12]: Increase primary	**Milestone 9** [I-12]: Increase primary clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1] Documentation of increased number of visits Baseline/goal: 60% increase over baseline in rural primary care clinic volume Data source: GE Centricity Scheduling Module Milestone 9 estimated incentive payment :$420,195 **Milestone 10** [P-X]: Assess efficacy of processes in place and recommend process improvements to implement, if any Metric 1: Identify opportunities, if any, to improve the expansion of primary care clinics into the rural areas Baseline/goal: To continuously improve processes and healthcare provided as well as look at further expansion Data source: Evaluation reports

081939301.1.4	***1.1.1 ESTABLISH MORE PRIMARY CARE CLINICS***	***1.1.1***	***INCREASE INFRASTRUCTURE DEDICATED TO HEALTHCARE FOR WOMEN***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.4* *081939301.3.5* *081939301.3.6*	*IT 12.1* *IT 12.2* *IT 12.5*	*Breast Cancer Screening* *Cervical Cancer Screening* *Second Teen Pregnancy 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 5 [P-X]: Establish baseline rates Metric 1 [P-X.1]: Establish base line rates Baseline/goal: McCamey clinic data from FY10. Estimating to be 350 visits Data source: GE Centricity Scheduling module Milestone 5 estimated incentive payment:$ 271,026		clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1] Documentation of increased number of visits Baseline/goal: 40% increase over baseline in rural primary care clinic volume Data source: GE Centricity Scheduling Module Milestone 8 estimated incentive payment :$ 289,934	Milestone 10 estimate incentive payment:$ 420,195
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $740,424	Year 3 Estimated Milestone Bundle Amount: $813,078		Year 4 Estimated Milestone Bundle Amount: $869,804	Year 5 Estimated Milestone Bundle Amount: $840,390
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,263,696				

Identifying Project and Provider Information*:*
Unique Category 1 Identifier: 094204701.1.1
Project Title and Category: 1.1.1 Expand Primary Care Clinic Infrastructure
Winkler County Memorial Hospital; TPI#094204701

Summary Information

- Provider: Winkler County Memorial Hospital is a 19-bed hospital in Kermit, Texas serving a population of approximately 7,200; City of Wink with a population of 920; Loving County with a population of 200, as well as Jal (population of 2,000) and Eunice (population of 2,500) located in Southeastern New Mexico.

- Intervention(s): This project will:
    - Increase outpatient volume by enabling community to be seen locally for outpatient issues vs. travelling up to 35-40 mile one way to neighboring cities
    - Expand primary care for surrounding patrons who have no other healthcare options in their local areas
    - Decrease use of Emergency Room at WCMH for non-emergent clinical needs
    - Increase clinical outpatient space for practitioners to exam patients; current space allows for 1.5 rooms per providers
    - With increased space, recruitment of qualified providers to enhance our practitioner availability for outpatient care will increase
- Need for the project: Currently, we have one physician and two mid-levels and recruitment for additional practitioners is hampered due to limitation of space for outpatient care as well as we are seeing approximately 58% of ER visits is for non-emergent needs.
- Target population: All residents residing in Winkler County, Loving County as well as Eddy County (NM); approximately 12,500 (not approximate, based on 2010 census)
- Category 1 expected patient benefits:
    - Increase patient care space available for practitioners
    - Increase recruitment efforts for local area to increase available practitioners for outpatient and inpatient care
    - Enable greater outpatient care for non-emergent needs for clinical conditions, i.e. Respiratory diseases, Diabetes control, COPD, Asthma, CHF, Hypertension, etc
- Category 3 outcomes:
    - OD-9, Right Care, Right Setting; IT-9.2 ED appropriate utilization:
        - Will assist in reducing ED visits for target conditions in CHF, Diabetes, ESRD, CV Disease, Hypertension, Substance Abuse, COPD, and Asthma

- Improvement targets will be in DY4 and DY5 based on data collected and established baseline rates in DY2 and DY3

Category 1: Infrastructure Development

Access to healthcare in our community has been limited for the past few years due to capacity restraints in our clinic space for patients and providers, antiquated facilities without proper access for all patients, and limitations on internal room space to provide a safe and comfortable place for patients to be seen. At present our community of 7,200 people travel a good distance, up to 35 miles roundtrip, for primary care due to severe space limitations, long wait times and available appointments for their primary care physician or mid-level. In order for WCMH to address this issue over the next four years, the RHC will evaluate and design a patient appointment system that opens more available appointment slots, provide reminders and other patient centered services to decrease the "No Show" and Cancellation rates, and align the schedules to achieve more provider capacity and efficiency

Project Description:

Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Projects plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care.

a) Expand primary care clinic space: WCMH will expand clinic space by designing and upgrading from an aged facility to a modern modular facility that will expand clinic space, i.e. increase exam rooms, add treatment rooms, and increase space for recruitment of additional practitioners

Starting Point/Baseline:

As of July 2012, current clinic capacity is 455 visits per month with a target (expected) of 857 for three providers. This decreased capacity prohibits readily available access to Medicaid, the uninsured, and others. Winkler County Rural Health Clinic employs the only 3 providers in 2 counties.

Rationale:

- **This project meets CN1 and CN3 as identified in the RHP 14 Community Needs Assessment.**

This is a priority project for our organization to alleviate the high cost of non-urgent visits. In order to provide preventive and primary care, we must first have the capacity to expand access for patients to these services. In adding space to our Rural Health Clinic, we will be able to provide an alternative care setting and avoid more costly ER and inpatient care.

Related Category 3 Outcome Measure:

OD- 9 Right Care, Right Setting: With expansion of our outpatient facilities space for patient care, WCMH will be able to have an impact on decreasing our ER over-use. We will directly connect that to IT-9.2 ED appropriate utilization which will:

1) Reduce all ED visits (including ACSC)
2) Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
3) Reduce Emergency Department visits for target conditions

a. Congestive Heart Failure
b. Diabetes
c. End Stage Renal Disease
d. Cardiovascular Disease /Hypertension
e. Behavioral Health/Substance Abuse
f. Chronic Obstructive Pulmonary Disease
g. Asthma

This project will also directly to Category 4 reportable measures in:

- RD-1. Potentially Preventable Admissions
- RD-2. 30-day readmissions
- RD-3. Potentially Preventable Complications (PPCs)
- RD-4. Patient-centered Healthcare
- RD-5. Emergency Department

Winkler County Memorial Hospital will not report on RD-6, Initial Core Set of Health Care Quality Measures. WCMH does not provide these services in our rural hospital.

Project Valuation:
WCMH brings care and treatment to a level of proactive response in promoting higher standards of community health through preventative care. Without the proper continuum of care, the Winkler County population, as well as patients from Southeastern New Mexico, often arrives at the ER for treatment. We have 58% non-emergent visits in our ED (monthly averages 49-52%). The creation of the WCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider.

Winkler County Memorial Hospital used a basic valuation tool to measure the efficacy of potential project. The tool was centered on the following questions:

- Does the project meet the waiver goals?
- Does the project address a pressing community need?
- Which population is being served?
- What is the project investment (Resources needed)?

After receiving input from outside consultation and visiting with local stakeholders, the WCMH Project was deemed to be a top priority in strengthening the health delivery system of Winkler County.

Milestones/Metrics:
P-1. Milestone: Establish additional/expand existing/relocate primary care clinics
P-1.1. Metric: Number of additional clinics or expanded hours or space

a. Documentation of detailed expansion plans
b. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.
c. Rationale/Evidence: It is well known the national supply of primary care does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and

therefore avoid more costly ER and inpatient care. RHPs are in real need of expanding primary care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

094204701.1.1	***1.1*** ***EXPAND PRIMARY CARE CAPACITY***	***1.1.1.*** ***ESTABLISH MORE PRIMARY CARE CLINIC(S)***	***WINKLER COUNTY MEMORIAL HOSPITAL INFRASTRUCTURE DEVELOPMENT***
Winkler County Memorial Hospital			***094202701***
Related Category 3 Outcome Measure(s):	***094204701.3.1***	***1.1 - Expand Primary Care Capacity***	***1.1.1 - Establish more primary care clinics***

Year 2 (10/1/2012 – 9/30/2013)	**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]. Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]. Number of additional clinics or expanded hours or space Baseline/Goal: Documentation of detailed expansion plans Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider Process Milestone 1 Estimated Incentive Payment*:* $ 87,302	**Process Milestone 2** [P-X]: Establish a baseline, in order to measure improvement over self Metric 1 [P-X.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Documentation of detailed expansion plans Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider Process Milestone 2 Estimated Incentive Payment: $ 95,242	**Improvement Milestone 1** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Total number of visits for reporting period Data Source: Registry, EHR, claims or other Performing Provider source Improvement Milestone 1 Estimated Incentive Payment: $ 95,518	**Improvement Milestone 2 [**I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [1-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Total number of visits for reporting period Data Source: Registry, EHR, claims or other Performing Provider source Improvement Milestone 2 Estimated Incentive Payment: $ 78,906
Year 2 Estimated Milestone Bundle Amount: $ 87,302	Year 3 Estimated Milestone Bundle Amount: $95,242	Year 4 Estimated Milestone Bundle Amount: $ 95,518	Year 5 Estimated Milestone Bundle Amount: $ 78,906
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 356,968			

Identifying Information:
Project Title: Prompt Care Center
Project Category and Option: 1.1.2 Expand Primary Care Access
Unique Identifier: 127298103.1.1
Performing Provider: Permian Regional Medical Center 127298103

Summary Information:
Provider: Permian Regional Medical Center is a 44 bed rural acute care facility that serves the community of Andrews, which has an approximate population of 16,000, as well as surrounding communities.

Collaboration: Ward Memorial Hospital agreed to transfer their Pass 1 DSRIP allotments to Permian Regional Medical Center. Ward Memorial was unable to fund a project therefore they agreed to collaborate with Permian Regional Medical Center in order to further enhance regional development of RHP 14.

Intervention(s): We will offer prompt care in an extended hours setting and provide additional primary care capacity to meet the needs of non-emergent visits to the emergency department.

Need for the project: Expanding primary care hours will allow those in need of care outside of existing clinic hours to seek medical attention. Currently there are no similar services provided in the community and with an insufficient amount of primary care physicians, patients are forced to seek services in the emergency room or outside of the community.

Target population: The prompt care clinic will have approximately 150 patient visits per month in DY3, 200 in DY4 and 250 in DY5. Out of this demographic, roughly 20% of these patients will qualify as indigent or Medicaid recipients.

Category 1 or 2 expected patient benefits: The project plan wishes to accommodate proper care and proper setting by reducing patient wait times, expanding clinic space and broadening clinic hours. Medicaid and indigent patients will benefit from expanded primary care by avoiding unnecessary emergency room visits. Low income patients will also benefit from a reduced cost of clinical care.

Project Description

Permian Regional Medical Center will expand primary care capacity by providing additional space and resources for physicians to meet the needs of the low income population that typically does not have access to prompt care. Initially, we will identify the services that are most critical to our population. We will then develop a clinical schedule that will increase the number of hours that are available to care for our patients. We will offer prompt care and partner with other healthcare providers to provide, but not limited to, dialysis services to expand the project to a broader population. We will provide better access to our patients so they can avoid costly trips to physicians located outside the county or to the emergency room improving the healthcare needs of our community.

Starting Point/ Baseline

We will acquire a building and staffing in the beginning to establish baseline data in late DY2. Currently there is no facility or services offered for prompt care in the community.

Rationale:

In our current system, more often than not, patients receive services in an emergent care setting for conditions that could be managed in a primary care setting. By expanding prompt care the primary care system would result in better outcomes, patient satisfaction and reduce cost of services.

Project 1.1.2 – Expand primary care capacity

a) Acquire prompt care space
b) Expand primary care hours
c) Expand primary care clinic staffing

Performance Milestones selected:

- 1.1.2 P-1 Establish new prompt care center
  Metric: Add prompt care clinic building and expand clinic hours

Improve Milestones selected:

- 1.1.2 I-12 Increase primary care visits and improve access for patients seeking services
  Metric: Documentation of decreasing the number of non-emergent visits to the emergency department at the hospital.

Permian Regional Medical Center will decrease the number of non- emergent visits by 3% in DY3, 4% in DY4 and 5% in DY5 over baseline.

Related Category 3 Outcome Measure(s)

OD-9 Right Care, Right Setting

There is a need to provide appropriate care in the appropriate setting:

Reduce non emergent care visits to the ED for all conditions

Relationship to other Projects

None

Relationship to other Performing Providers' Projects in the RHP

None

Plan for Learning Collaborative

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaborative would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

Andrews County is located in a low income rural area needing prompt care and will partner with other healthcare providers to offer, but not limited to, dialysis services. The prompt care clinic will have approximately 150 patient visits per month in DY3, 200 in DY4 and 250 in DY5. Out of this demographic, roughly 20% of these patients will qualify as indigent or Medicaid recipients. The non-emergent emergency room visits would decrease better serving the patients. An expansion of primary care would reduce costs, provide efficiencies and improve care for these patients by allowing access to care locally.

127298103.1.1	1.1	***1.1.2***	***PROMPT CARE CENTER***
-Permian Regional Medical Center-			127298103
Related Category 3 Outcome Measure(s):	*127298103.3.1*	*IT 9.2*	*Reduce Non Emergent ED Visits*

Year 2 (10/1/2012 – 9/30/2013)	**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]: Establish new prompt care clinic Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Baseline - None/Goal – Documentation of detailed Data Source: Detailed expansion plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $769,349	**Improvement Milestone 1 [I-12]:** Increase primary care clinic volume of visits and evidence of improves access for patients seeking services by averaging 150 patient visits per month Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Baseline/Goal: Baseline: 3% decrease in non-emergent ED visits Data Source: EMR or chart Improvement Milestone 1 Estimated Incentive Payment: $891,774	**Improvement Milestone 2**[I-12]: Increase primary care clinic volume of visits and evidence of improves access for patients seeking services by averaging 200 patient visits per month Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: Baseline: 4% decrease in non-emergent ED visits over baseline Data Source: EMR or chart Improvement Milestone 2 Estimated Incentive Payment: $900,993	**Improvement Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improves access for patients seeking services by averaging 250 patient visits per month Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: 5% decrease in non-emergent ED visits over baseline Data Source: EMR or chart Improvement Milestone 3 Estimated Incentive Payment: $748,907
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $769,349	Year 3 Estimated Milestone Bundle Amount: $891,774	Year 4 Estimated Milestone Bundle Amount: $900,993	Year 5 Estimated Milestone Bundle Amount: $748,907
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,311,023			

Identifying Information
Title of Project: ***Expand primary care capacity (1.1.1)***: Recruit additional providers, expand hours, and expand clinic space
RHP Project Identification Number: 112711003.1.1
Reference Number of Project: 1.1.1
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): ORMC will increase access to primary care by recruiting and establishing at least 3 new primary care physicians into its service area. Based on currently available information and patient data, ORMC will look at establishing one family practice physician, one internal medicine physician, and one geriatrician in order to better serve both the Medicaid/Medicare populations within the area.

- Need for the project: RHP 14 identified shortages in primary care as evidenced by the region's placement well below Texas and National averages. Ector County has also been designated as medically underserved for its population, with a lack of primary care physicians being an attributing factor.

- Target population: ORMC looks to target the population that does not currently have adequate access to primary care. Approximately 35% of the patients ORMC serves are considered indigent or Medicaid. With development of several other DSRIP projects, and the expansion of primary care resources, ORMC will be able to direct and coordinate care for both sets of patients.

- Category 1 or 2 expected patient benefits: Based on currently available data and our current patient volumes, ORMC expects to be able to increase its primary care encounters through physician clinic visits by up to 20% by the conclusion of the Waiver.

- Category 3 outcomes: IT-6.1 - Patient Satisfaction - Our goal is to increase patient's satisfaction scores in the domain of "timeliness of care, appointments, and information." ORMC will need to develop a process and procedure in order to collect this data, with development of a baseline taking place in DY3.

Project Description:

Through the recruitment of three primary care physician, Odessa Regional Medical Center (ORMC) will increase the patient's access to primary care, enabling patients to receive the right care at the right time and in the right setting, leading to an increase in positive health outcomes. In order to accomplish this, ORMC will need to establish each primary care physician; including location, staffing, and EHR implementation. These providers will look at increasing access to the community which is in dire need of extra primary care providers as demonstrated by the Community Needs Assessment. A concerted effort will focus on developing a patient base towards the population that is lacking in providers and where next available appointment wait time is detrimental.

Project Goals: Resources will be increased in order to improve patient access to Primary care, which includes: health promotion, disease prevention, health maintenance, and the diagnosis of treatment of acute and chronic illnesses. Infrastructure will also need to be developed in order to accommodate the primary care clinics, including clinic space, clinic staff, and information technology development. ORMC has set the following goal(s) for its expansion of primary care: Increase primary care patient encounters. The program also addresses the following regional needs: access to primary care (CN1), primary care recruitment (CN5), and the availability of public health and preventive measures (CN14).

Challenges/Issues Faced by Provider:

- Recruiting and identifying locations for new primary care clinics
- Identifying physician supervision for mid-level support
- Recruiting staff for expansion of clinic hours

5-year Expected Outcome:

- ORMC will increase access to primary care within its clinics as evidenced by a 20% increase from baseline year in primary care encounters through the establishment of three new primary care providers.
- Based on previous years, ORMC expects to have the following impact:
  Year 3: 2,400 patients served with 1,200 being Medicaid/indigent
  Year 4: 2,760 patients served with 1,380 being Medicaid/indigent
  Year 5: 2,880 patients served with 1,440 being Medicaid/indigent
  Total amount of patients served is expected to be approximately 8,040.

- *ORMC will use DY 3 in order to establish a true baseline that will be used to expand upon during the remaining demonstration years.

Starting Point/Baseline: Baseline will be established in DY3

Rationale:

Access to primary care has become increasingly difficult within the region, resulting in poor overall management of the populations' health. RHP 14 has higher death rates than the Texas average in: heart disease, chronic lower respiratory disease, influenza/pneumonia, and cancers of colon, rectum, and anus. With 61 primary care providers per 100,000 people, RHP 14 ranks below the Texas average of 70 per 100,000 resulting in a lack of access to management of care. This issue will only continue as the population increases at its current rate. Improving access to primary care will decrease misuse of the ED and lower healthcare costs. Across the state of Texas, ED visits increased by 28.6% with RHP 14 following this trend. Additionally, routine preventative medicine services will improve the overall health of the populations served in this area of Texas. In 2010, less than 50% of the patients in RHP 14 accessed or had access to specific aspects of preventative care such as stool for occult blood, colonoscopy, vaccinations for influenza and pneumonia, mammograms and pap smears.

Project Components: Through the increase in primary care program, ORMC will meet the following project components:

a) *Establishment of primary care physicians.* ORMC will recruit and establish primary care physicians at identified locations. This includes building out physician locations, clinic staffing, and IT infrastructure.

b) *Develop resources necessary for increasing clinic hours.* Increasing access to primary care will be through two different avenues. ORMC will recruit and establish new primary care physicians, and look to increase hours at existing primary care locations.

Relationship to Other Projects:

Primary care expansion will correlate with several projects implemented within the RHP. Management of a patients care would allow for identification of health issues needing chronic care management, or possible referral to specialty clinics. Easier access would benefit those referred by patient navigators, which have been established through the reduction in unnecessary visits campaign. ORMC will be monitoring the mortality rates associated with primary care management and look to improve these rates when compared to the state.

This project will relate to the following Category 4 reporting domains by increasing access to preventative care, screening, and disease management: RD 1 (Potentially Preventable Admissions), RD 2 (30 Day Readmissions), and RD 4 (Patient Centered Healthcare).

Related Category 3 Outcome: [OD-6] Percent Improvement over Baseline of Patient Satisfaction Scores **(**Outcome Domain 6 – Patient Satisfaction)

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project meets the goals of the Waiver by increasing access to primary care, which will transform the entire health care delivery pattern for the community by preventing inappropriate use of the ED and promoting improved health outcomes for patients. The population served will be broad, as primary care providers treat all manner of ailments (and/or are equipped to make referrals). The cost to implement this project will be high, as increasing hours, expanding space, and recruiting and hiring new physicians will take significant time, money, and effort.

112711003.1.1	*1.1*	*Expand primary care capacity (1.1.1)*	*Expand Primary Care Capacity through the recruitment and establishment of primary care practices*
Odessa Regional Medical Center		*112711003*	
Category 3 Outcome Measure(s): Percent Improvement Over Baseline of Patient Satisfaction Scores	*112711003.3.1*	*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)
Process Milestone 1 [P-5]: Train/hire additional primary care providers and staff. ORMC will recruit and establish at least three (3) primary care physicians into the area. **Metric 1 [P-5.1]:** Documentation of increased number of primary care physicians successfully recruited into the area **Data Source:** Documentation of the new provider contracts Process Milestone 1 Estimated Incentive Payment: $1,240,876	**Improvement Milestone 1 [P-X]:** ORMC will develop and implement patient encounter productivity targets for newly established physicians within first 6 months of the fiscal year, and increase primary care encounters by 10% compared to baseline. **Metric 1 [I-X.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Projected Impact:** 2,400 total patients with 1200 Medicaid/ Indigent **Data source**: EHR **Improvement Target 1 Estimated Incentive Payment:** $1,343,066	**Improvement Milestone 2 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. ORMC will increase identified primary care clinic encounters by 15% from previous reporting year at identified clinics. **Metric 1 [I-12.1]:** Documentation of increased primary care encounters, demonstrating improvement from prior reporting period. **Projected Impact:** 2,760 total patients with 1,380 Medicaid/ Indigent **Data Source**: EHR **Improvement Target 2 Estimated Incentive Payment :** $1,334,672	**Improvement Milestone 3 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. ORMC will increase identified primary care clinic encounters by 20% from previous reporting year at identified clinics. **Metric 1 [I-12.1]:** Documentation of increased primary care encounters from baseline, demonstrating improvement from prior reporting period. **Projected Impact:** 2,800 total patients with 1,440 Medicaid/ Indigent **Data Source**: EHR **Improvement Target 3 Estimated Incentive Payment:** $1,095,498

Year 2 Estimated Milestone Bundle Amount: $1,240,876	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,343,066	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,334,672	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,095,498
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 5,014,112			

Identifying Information

Title of Project: Expand primary care through the development of a mobile care unit
RHP Project Identification Number: 112711003.1.2
Reference Number of Project Option Planning Protocol: 1.1.3
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): The Mobile Health Clinic will serve ORMC's primary service area, along with outreaching communities that might not have access to primary care services. ORMC will identify a service area in which to deploy the mobile clinic in order to be most effective in reaching a larger population. The clinic will be set up to offer various primary care services, including screenings recommended by the USPSTF and American Heart Association.

- Need for the project: With 10 of the 16 counties within RHP 14 being considered frontier, many patients have to drive long distances for medical services making distance a barrier. Along with this, the community needs assessment has stated that RHP 14 has a higher percentage of "adults who did not access most of these specific aspects of preventative care than Texas the U.S."

- Target population: The target population will be patients within our primary and secondary service areas that are unable to access appropriate care due to distance. Approximately 35% of the patients ORMC serves are considered indigent or Medicaid, a significant portion of which are unable to access appropriate care due to distance.

- Category 1 or 2 expected patient benefits: Patients that would otherwise not have access to care due to distance, will now have the opportunity to receive primary care services that would otherwise not be available.

- Category 3 outcomes: IT-12.5 - Other USPSTF endorsed screening outcome measure - The mobile clinic will provide patients access to screenings that have been recommended by the United States Preventive Services Task Force and American Heart Association, including:
    - Abdominal aortic aneurysm
    - High blood pressure screenings
    - Ankle brachial index

Project Description:

Through the development of a mobile primary care unit, the surrounding rural and Odessa communities will have the opportunity to access a variety of health resources in a timely and cost effective manner. Specifically, ORMC will equip the mobile unit with capabilities that will offer preventive screenings particular to the RHP population. These screenings will begin with cardiac related studies to include: High Blood Pressure, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm screenings. Radiology technicians capable of performing these studies will staff the clinic along with mid-level support. Radius of travel and clinic hours will be dependent on capabilities of the unit.

The mobile clinic will look at expanding capabilities once implemented and will look at increasing its primary care capabilities in order to reach a bigger population within RHP 14.

Project Goal:

Expand the capacity of primary care through a mobile care unit to better accommodate the needs of the patient population and community so that patients can receive the right care, at the right time, in the right setting. Currently ORMC serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. Approximately 35% of the patients ORMC serves are considered indigent or Medicaid. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively) which ORMC will be better suited for serving through the development of the mobile unit.

ORMC has set the following goal(s) for the mobile health program: increase access to primary care as evidenced by mobile clinic encounters, and increase primary care screenings. The project will address the following regional needs: access to primary care (CN1), diabetes and cardiovascular screening and education (CN9/10), availability of public health and preventive measures (CN14), and enhancing overall patient experience (CN19).

Challenges/Issues Faced By Provider:

- Identifying vendor most capable and compatible with existing resources
- Mid-Level support
- Medical staff training with hardware/software
- Service identification

5-year Expected Outcome:
Earlier identification and better management of chronic conditions, as well as better access for services not available otherwise. Based on previous years, ORMC expects to have the following impact:

- Year 3: 1,200 patients served with 300 being Medicaid/indigent
- Year 4: 1,380 patients served with 345 being Medicaid/indigent
- Year 5: 1,620 patients served with 405 being Medicaid/indigent

Starting Point/Baseline: Develop a new primary care mobile clinic.

Rationale:

RHP 14 has had a higher percentage of patients who are unable to access primary care due to the high cost, when compared to the Texas average from 2007-2010. Access to affordable care has been an issue within the region, leading to poor health outcomes and a high percentage of preventable hospitalizations. In addition, access to primary care has become increasingly difficult within the region, resulting in poor overall management of the population's health. RHP 14 has higher death rates than the Texas average in: heart disease, chronic lower respiratory disease, influenza/pneumonia, and cancers of colon, rectum, and anus. With 61 primary care providers per 100,000 people, RHP 14 ranks below the Texas average of 70 per 100,000 resulting in a lack of access to management of care. This issue will only continue as the population increases at its current rate. Improving access to primary care will decrease misuse of the ED and lower healthcare costs. Across the state of Texas, ED visits increased by 28.6% with RHP 14 following this trend. Additionally, routine preventative medicine services will improve the overall health of the populations served in this area of Texas.

RHP 14 covers very large counties, including hundreds of miles. In some areas, it may take patients hours to drive to Performing Provider facilities. Therefore, a mobile clinic offers the benefits of taking the services to the patients, which will help keep them healthy proactively. Establishing a mechanism for timely, affordable care would lead to improved outcomes and would provide patients with education on how to manage their condition.

Project Components: Through the development of a mobile program, ORMC will meet the following project components:

a) *Identify more primary care resources*: The mobile clinic will be staffed dependent on the services it will offer. Currently a mid-level provider has been identified to offer primary care services, along with a radiology technician to offer screenings. Additional staffing will be dependent upon additional services the mobile clinic will offer.

b) *Purchase and modify the mobile uni*t. ORMC is currently exploring options in regards to the mobile unit. After purchasing, modifications will need to take place to ensure the unit is fixed with the resources necessary to obtain its goal

Relationship to Other Projects:

A mobile health unit would expand our primary care capacity along with several other initiatives pertinent to the RHP. The mobile unit would identify patients in need of further follow up with a specialty clinic and/or chronic care management leading to a decrease in unnecessary visits to Emergency Department.

Related Category 3 Outcome Measure: **[**IT-12.5] Other USPSTF-endorsed screening outcome measure)

This outcome measure will include **THREE** types of screenings, two recommended by the U.S. Preventive Services Task Force and one recommended by the American Heart Assocation, including: High Blood Pressure Screenings, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm screenings.

Relationship to Other Projects:

This project will further develop the expansion of primary care in RHP 14, a major goal of all providers within the region. Mobile capabilities will assist in screening patients in hopes of keeping patients from inappropriately utilizing the emergency department and will assist in identifying a patient population in which to tailor ORMC's patient navigator program.

This project will tie to the following Category 4 measures by increasing the effective management of high risk diabetes patients' conditions: RD1 (Potentially Preventable Admissions), RD 2 (30 day readmissions); and RD 4 (Patient centered healthcare: Medication management).

Relationship to other providers' project within the RHP:

N/A

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project meets the goals of the Waiver by increasing indigent and rural patients' access to preventative and primary care, which will increase short and long term patient outcomes. Additionally, these improved outcomes will affect the quality of life for the affected patients and will decrease the cost of providing services to the community, allowing for reinvestment of savings into other areas of improvement.

112711003.1.2	***1.1***	***Expand mobile clinics (1.1.3)***	***Expand Primary Care Capacity through the development of mobile clinics***
Odessa Regional Medical Center		***112711003***	
Category 3 Outcome Measure(s): Other USPSTF-endorsed screening outcome measure	***112711003.3.2*** ***112711003.3.3*** ***112711003.3.4***	***12.5***	***Increase amount of screenings performed***
Year 2 (10/1/2012 – 9/30/2013)	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-X]: Complete planning process for implementation of mobile health clinic, including: resources, staffing, and service area development. **Metric 1 [P-X.1]:**Submission of planning documentation **Data source: Planning Documentation.** Documentation of completion of all items described by the RHP plan for this measure. **Process Milestone 1 Incentive Payment:** $1,116,788	**Process Milestone 2 [P-3]:** Implement a mobile health clinic program **Metric 1 [P-3.1]:** Documentation of mobile clinic expansion **Data source**: New Primary Care Schedule/EHR **Process Milestone 2 Incentive Payment:** $604,380 **Process Milestone 3 [P-5]**: Train/hire additional primary care providers and staff. **Metric 1 [P-5.1]:** Documentation of increased number of providers and staff **Projected Impact:** 1,200 total patients with 300 Medicaid/ Indigent **Data Source:** Hiring Documentation Process Milestone 3 Incentive Payment: $604,379	**Improvement Milestone 1 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Improvement Target:** ORMC will increase identified primary care clinic encounters by 15% from previous reporting year at identified clinics. **Metric 1 [I-12.1]:** Documentation of increased primary care encounters, demonstrating improvement from prior reporting period. **Projected Impact:** 1,380 total patients with 345 Medicaid/ Indigent **Data Source**: EHR **Improvement Milestone 1Incentive Payment:**	**Improvement Milestone 2 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Improvement Target:** ORMC will increase identified primary care clinic encounters by 20% from previous reporting year at identified clinics. **Metric 1 [I-12.1]:** Documentation of increased primary care encounters from baseline, demonstrating improvement from prior reporting period. **Projected Impact:** 1,620 total patients with 405 Medicaid/ Indigent **Data Source**: EHR **Improvement Milestone 2 Incentive Payment:** $985,949

		$1,201,204	
Year 2 Estimated Milestone Bundle Amount: $1,116,788	Year 3 Estimated Milestone Bundle Amount: $1,208,759	Year 4 Estimated Milestone Bundle Amount: $1,201,204	Year 5 Estimated Milestone Bundle Amount:$985,949
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 4,512,700			

Identifying Information:
Title of Project: Introduce, Expand, or Enhance Telemedicine/Telehealth
RHP Project Identification Number: 112711003.1.3
Reference Number of Project Option Planning Protocol: 1.7.1
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): This project will implement a telemedicine program based on the community demand. ORMC will use the "hub and spoke" model in which ORMC will serve as the hub, and work with outlying communities to set up the infrastructure needed to communicate with our services. Current needs assessment data has revealed the need for a neuro-telemedicine program due to the need for timely stroke intervention.

- Need for the project: Currently distance is a major barrier in medical treatment for patients experiencing major medical conditions. With 10 out of the 16 counties being considered frontier, timely care is critical for patients experience symptoms of a stroke. With Cerebrovascular disease being the 5th leading cause of death in RHP 14, a telemedicine program that could assist in timely intervention would be able to decrease mortality rates.

- Target population: The target population would be those presenting themselves to outlying facilities which might need further evaluation by a higher level of care. Currently ORMC is working with facilities within RHP 14 as well as its surrounding areas that are in need of these services. ORMC expects the approximately 35% of ORMC's patients considered indigent or on Medicaid will also benefit greatly from this project because of the transportation challenges commonly faced by the region's low-income population.

- Category 1 or 2 expected patient benefits: The project will continue to increase its tele-medicine encounters; ORMC aims to increase these encounters by up to

20% when comparing DY3 and DY5. ORMC will also look at expanding its tele-medicine program to other service lines if a need is presented.

- Category 3 outcomes: IT-3.2 - Stroke/CVA 30 Day Readmission Rate - Our goal is to reduce the 30-day readmissions regarding stroke (CVA) patients by DY5 in amounts to be established as part of the initiative.

Project Description:

Develop a telemedicine program to provide access to specialists for the diagnosis and treatment of conditions that have been identified as an essential need for the surrounding communities. Steps will include identifying the conditions most impacted in the community, identifying specialist partners, obtaining the requisite equipment, implementing the program, and improving the access and health outcomes for members of the community through the program.

Project Goal(s) and Relationship to Regional Goals:

Identify services most needed for surrounding communities and provide Tele-health services to increase patient access.

Through the implementation of a tele-medicine program, ORMC will: increase specialty access to the region through tele-medicine. This project will also address the following regional goals: access to specialty services (CN3) and enhancing the overall patient experience (CN19)

Challenges/Issues Faced by Provider:

- Identifying a vendor capable of providing telemedicine services and that is compatible with existing resources/infrastructure
- Physician support with on-call coverage
- Training for spoke/outlying hospitals
- Medical staff training with hardware/software

Baseline Data: Program not established.

Rationale:

There are only two counties out of sixteen within RHP 14 that are not considered rural (Ector and Midland), with ten being considered frontier. According to the community needs assessment, 912 out of the 1485 beds in RHP 14 are amongst three hospitals, and nine of the 21 hospitals in RHP 14, are in the metro areas of Midland and Odessa. This disparity in care leaves many of these counties without the resources needed to adequately identify and treat various conditions, especially when outside Ector and Midland Counties.

Odessa Regional Medical Center will use the Community Needs Assessment developed for the RHP to identify which services would be most beneficial for the region. At this time, ORMC believes a Neuro-telemedicine program would be most

beneficial, given an emphasis on timely care and capabilities of outlying hospitals. This will be confirmed by analyzing the needs assessment even further along with other data gathered and coordination between other performing providers in the RHP.

As a Certified Primary Stroke Center, Odessa Regional Medical Center has the resources needed to establish in outlying communities access to stroke care. Through the Neuro-telemedicine program, the surrounding communities will have the opportunity for their patients to access these resources in a timely and cost effective manner. According to the Ector County Health Department, Ector County is above the national average in three of the leading causes of stroke, including but not limited to: adult smoking, adult obesity, and physical inactivity.

	Ector County	National Benchmark
Adult Obesity	32%	25%
Adult Smoking	19%	14%
Physical Inactivity	28%	21%

Cerebrovascular disease was also the 5th leading cause of death within RHP 14 and had a higher mortality rate (49.1%) than Texas (45.8%).

Project Components:

Through the establishment of a Tele-medicine program, ORMC will meet the following project components:

a) *Identify service line most beneficial to region*. Tele-medicine can be very beneficial for a region such as RHP14 due to the distance between healthcare providers. A needs assessment will be developed to ensure ORMC will develop a service that is most needed for the community.

b) *Identify current technical capabilities and ways to improve upon them if need be*. A needs assessment will need to be developed in order to identify current capabilities within the hospital network, and ensure appropriate infrastructure is in place.

c) *Identify a vendor for tele-medicine implementation*. Identifying a vendor that has a compatible system with our EHR will assist in capturing data and help in streamlining processes involved. A vendor that has the ability to support multiple services would also serve beneficial if another service becomes needed within the region.

Related Category 3 Outcome: Stroke (CVA) 30 day readmission rate
OD 3 Potentially Preventable Readmissions
Improvement target: TBD

Relationship to Other Projects:

Telemedicine will relate with the increase in specialty care delivered by ORMC. Tele-medicine capabilities would also link to its patient care navigator program, as management after stroke would be essential for reducing re-admissions caused by CVA.

This project is related to the following Category 4 Reporting Domains because it will increase access to specialty care for those at risk or in early stages of conditions requiring preventative care (as opposed to waiting until a condition is acute to treat it): RD 1 (Potentially Preventable Admissions) and RD 4 (Patient centered healthcare).

Relationship to Other Projects in the RHP: N/A

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks to increase access to specialists in rural communities, while reducing the burden on patients (travel, time, expense) in acquiring this treatment. Additionally, the project should result in reduced costs for the health care delivery system, in that patients at risk or needing preventative/primary/specialty care for the targeted conditions are more likely to be identified before their conditions are acute (requiring expensive inpatient/ED care).

112711003.1.3	***1.7.1***	***Develop Tele-medicine program (1.7.1)***	***Increase number of encounters for telemedicine program***
Odessa Regional Medical Center		***112711003***	
Category 3 Outcome Measure(s):	***112711003.3.5***	***IT-3.2***	***Decrease the number of re-admissions for Stroke (CVA) 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-1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine. ***Metric 1 [P-1.1]:*** Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel ***Data source:*** Needs assessment ***Milestone Incentive Payment:*** $310,219 **Process Milestone 2 [P-7]:** Create plan that identifies current technical properties and bandwidth of current network for implementation of telemedicine in DY 3. ***Metric 1 [P-7.1]:*** Documentation of bandwidth capacity in relationship to program needs ***Data source:*** Assessment/program	**Process Milestone 3 [P-3]:** Implement tele-medicine program for selected health services, based upon regional and community need and develop-baseline number of encounters. ***Metric 1 [P-3.1]:*** Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents ***Data source***: Program materials ***Process Milestone 3 Incentive Payment:*** $671,533	**Improvement Milestone 1 [I-12]:** Increase the number of telemedicine visits for specialty identified as high need by 15% compared to baseline year. ***Metric 1 [I-12.1]:*** Number of telemedicine visits. ***Data source***: EHR ***Improvement Milestone 1 Incentive Payment:*** $333,668 **Process Milestone 4 [P-1]:** Conduct needs assessment to identify needed specialties for expansion of telemedicine program. ***Metric 1 [P-1.1]:*** Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel	**Improvement Milestone 2 [I-12]:** Increase the number of telemedicine visits for specialty identified as high need by 20% compared to baseline year. ***Metric 1 [I-12.1]:*** Number of telemedicine visits. ***Data source***: EHR ***Milestone Incentive Payment:*** $547,749

plan ***Milestone Incentive Payment:*** $310,219		***Data source****:* Needs assessment ***Process Milestone 4 Incentive Payment:*** $333,668	
Year 2 Estimated Milestone Bundle Amount: $620,438	Year 3 Estimated Milestone Bundle Amount: $671,533	Year 4 Estimated Milestone Bundle Amount: $667,336	Year 5 Estimated Milestone Bundle Amount:$547,749
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 2,507,056			

Identifying Information

Title of Project: Improve Fetal Outcomes for Diabetic Pregnancies.
RHP Project Identification Number: 112711003.1.4
Reference Number of Project Option Planning Protocol: 1.9.3
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): Provide Gestational Diabetes Care to patients through the Perinatal Center associated with Odessa Regional Medical Center. This would include consultations with a dietician and/or a certified diabetes educator, along with development of treatment programs in collaboration with their perinatal physician, their OB physician, and dietician/diabetes educator. Follow up consultations will be provided in order to prevent avoidable complications.

- Need for the project: Currently the Perinatal Center does not have the capabilities to adequately treat gestational diabetes, leading to issues with access and timeliness of care. Development of this program will give our current perinatal center the abilities to better manage patients with this condition.

- Target population: The American Diabetes Association estimates that up to 18% of all pregnancies are affected by gestational diabetes. Additionally, the Texas Department of Human Services estimates that women of Hispanic origin have a 5-8% chance of developing gestational diabetes. This project will target all women, but particularly the 53% of the population in Ector County that is of Hispanic origin. ORMC expects that approximately 55% of the Perinatal Center's patients are considered indigent or covered under Medicaid. Once the gestational diabetes program is established, this percentage of patients is expected to increase.

- Category 1 or 2 expected patient benefits: The Perinatal Center associated with ORMC will offer more appointments specifically for patients with gestational diabetes and in a timely manner.

- Category 3 outcomes: IT-1.10 - Diabetes Care: HbA1c poor control (>9.0%) - An increase in better care plans and compliance as evidenced by more patients with an HbA1c below 9.0%.

Project Description:

The community needs assessment identifies premature diabetes and prenatal/perinatal care as lacking in RHP 14. The Perinatal Center at Odessa Regional Medical Center has the capabilities to offer Perinatal Care to high risk pregnancies, but does not currently have adequate resources to timely manage Gestational Diabetes Mellitus (GDM) or Pre Gestational Diabetes Mellitus. Development of a Gestational Diabetes and Pre-Gestational Diabetes program would look at increasing access and better managing these patients, offering more timely care to a population that would otherwise not receive it.

Project Goal(s) and Relationship to Regional Goals:

Odessa Regional Medical Center will develop and implement a Gestational Diabetes program to educate and monitor patients, therefore, improving fetal outcomes. We propose providing a structured program that involves physicians, perinatal nurses, and a diabetic educator to provide timely care to the region's population.

ORMC has set the following goals for the gestational diabetes program: increase gestational diabetes appointments available, increase the amount of gestational diabetes appointments seen, and reduce the wait time for next routing appointment for gestational diabetes. The program also addresses the following regional needs: access to specialty services (CN3), access to women's health services (CN8), diabetes screening and education (CN9), and enhancing the overall patient experience (CN19).

Challenges/Issues Faced By Provider:

- 70.9% of births in Ector County occur in women who are considered low income, meaning that access to medical care remains difficult regardless of clinic resources
- Difficulties with the Medicaid authorization processes may lead to physicians to drop many Medicaid patients
- Ensuring populations compliance with diabetes treatment plans

5-year Expected Outcome:

Through an increase in access, the perinatal center at Odessa Regional Medical Center will improve clinical outcomes for pregnant women with Gestational Diabetes,

therefore, anticipate decreasing the rate of stillbirths, macrosomia, preterm labor, and birth trauma related to diabetes in pregnancy.
Based on previous years, ORMC expects to have the following impact:

- Year 3: 4,000 patients served with 2,000 being Medicaid/indigent
- Year 4: 4,400 patients served with 2,200 being Medicaid/indigent
- Year 5: 4,600 patients served with 2,500 being Medicaid/indigent
- Total amount of patients served is expected to be approximately 13,000.

- *ORMC will use DY 3 in order to establish a true baseline that will be used to expand upon during the remaining demonstration years.

Starting Point/Baseline:

ORMC is currently operating a Maternal-Fetal Medicine Program aimed at serving high risk pregnancies, but does not have the resources specific to care for those impacted by (pre)gestational diabetes.

Rationale:

The American Diabetes Association estimates that up to 18% of all pregnancies are affected by gestational diabetes. Gestational diabetes places these women at a greater risk for pregnancy complications including preeclampsia, prematurity, macrosomia (birth weight greater than 9lbs 15ounces), neonate respiratory difficulties, neonate hypoglycemia, birth injury and stillbirth. According to the Texas Department of Human Services, in 2007, 50.3% of the premature births were from Hispanic mothers. Women of Hispanic origin have a 5-8% chance of developing gestational diabetes compared to a 1.5-2% risk in non-Hispanic white women. Approximately 53% of the population in Ector County is of Hispanic origin. With proper diet, medication and monitoring complications from gestational diabetes can be controlled.

The Regional Healthcare Partnership 14 Community Needs Assessment identified Diabetes is one of the major causes of premature death in the within the region and disproportionately affects some racial and ethnic populations. Among the Type I diabetic populations in Texas, almost 19% of primary payment for hospitalization in 2006 was provided by Medicaid, compared to 15% by Medicare. Among Type II diabetics, Medicaid was the primary payment source for 10% of discharges in 2008, compared to 43% by Medicare. The percentages of low birth weight babies and diabetes among adults are similar for the region and Texas, with an average between 8% and 10%. This RHP also has a higher teen birth rate than Texas, with an average of 74% compared to Texas as a whole at 64%.

The community needs assessment also highlights maternal/child health outcomes and the RHP's issues with low birth rates due to maternal exposure to health risks, and an infant's current future morbidity and premature mortality risk. The RHP has recognized low birth weight as an area for improvement, along with developing ways to increase proper prenatal and perinatal care, due to 40% of pregnant woman not receiving prenatal care in the first trimester and 9% of babies having low birth weights.

Project Components:

Through the establishment of a gestational diabetes program, ORMC will complete the following component:

a) *Identify resources needed for implementation of a gestational diabetes program.* Resources that can manage GDM appropriately will be difficult to find due to the specialized nature of the condition. Specialized support staff will also be hired in order to offer the best care possible.

b) *Collection of baseline data in regards to access to GDM appointments.* Currently the clinic does not have the capacity to manage gestational diabetes resulting in lengthy waits before the next available appointment. ORMC will like to see significant improvements in this metric after the program has been implemented. Baseline data will look to be collected in DY 3.

c) *Implement Gestational Diabetes Program*. Establish the program in order to serve a population that would not have access to this care otherwise.

Relationship to Other Projects:

Odessa Regional Medical Center is making a concerted effort to reduce the prevalence of diabetes in RHP 14. Along with Gestational Diabetes program, ORMC is developing a chronic care management program focused on the identification and management of diabetes through its inpatient and outpatient program.

This project should relate to the following Category 4 Reporting Domains by reducing the occurrence of gestational diabetes-related complications before, during, and after birth and increasing the management of patient's conditions before they become acute episodes: RD 2 (30 Day Readmissions) and RD 4 (Patient Centered Healthcare).

Relationship to other providers' projects in the RHP: N/A

Related Category 3 Outcome: IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%).

Valuation Narrative:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This specific project aims to reduce expensive and potentially avoidable complications associated with giving birth increasing patient access to specialty providers, making it a valuable project for the community. The program will touch many in the community due to the high incidence of diabetes, pre-diabetes, and gestational diabetes in the Region, and because improving perinatal health outcomes not only affects the mother and infant, but also their families and support networks.

112711003.1.4	***1.9.3***	***Improve Fetal Outcomes for Diabetic Pregnancies.***	***Increase number of GDM Encounters and patients with self-management goals***
Odessa Regional Medical Center		***112711003***	
Category 3 Outcome Measure(s):	***112711003.3.6***	***IT-1.10***	***Increase patient population that meet HbA1C goal***
Year 2 (10/1/2012 – 9/30/2013)	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 Measure 1 [P-X]: Complete planning and acquisition of resources for Gestational Diabetes Mellitus program and integration with current operation of perinatal program. (P-X) **Metric 1 [P-X.1]:** Plan documentation **Data Source**: Gestational Diabetes Action plan **Milestone Incentive Payment:** $992,701	**Process Measure 2 [P-11]:** Launch/expand a specialty care clinic ORMC will expand the Maternal-Fetal Medicine Program to include a Gestational Diabetes component, incorporating the participation of physicians, perinatal nurses, and a diabetic educator. **Metric [P-11.1]:** Establish/expand specialty care clinics **Projected Impact:** 4,000 patients with 2,000 under Medicaid/Indigent **Data source**: Documentation of expanded specialty care clinic **Milestone Incentive Payment:** $537,226 **Process Milestone 3 [P-3]:** Collect baseline data for wait times, backlog, and/or return appointments in specialties. ORMC will establish a baseline for decreasing wait time for first	**Improvement Milestone 1 [I-23]:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. ORMC will increase the number of available specialty appointments for the Gestational Diabetes patients by 10% over baseline year. **Metric 1 [I-23.2]:** Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. **Projected Impact:** 2,760 total patients with 1,380 Medicaid/ Indigent **Data source:** EHR and/or claims **Improvement Milestone Incentive Payment:** $533,868 **Improvement Milestone 2 [I-30]:** Reduce the number of specialty clinics	**Improvement Milestone 3 [I-23]:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. ORMC will increase the number of available specialty appointments for the Gestational Diabetes patients by 15%. (I-23) **Metric 1 I [I-23.2]:** Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. **Projected Impact:** 2,800 total patients with 1,440 Medicaid/ Indigent **Data source:** EHR and/or claims **Milestone Incentive Payment:** $438,198 **Improvement Milestone 4 [I-30]:** Reduce the number of specialty clinics with waiting times for next routine appointment. ORMC will reduce the

	appointment for patients with GDM or Pre GDM. **Metric 1 [P-3.1]:** Number of appointments in clinic management system with diagnosis of GDM or Pre GDM. **Data source**: EHR, administrative records **Milestone Incentive Payment:** $537,227	with waiting times for next routine appointment. ORMC will reduce the waiting times for next routine appointment, at the Regional Perinatal Center, for patients with Gestational Diabetes by one day. **Metric 1 [I-30.1]:** Next routine appointment of more than X calendar days. (I-30.1) **Data source**: Appointment scheduling system **Milestone Incentive Payment:** $533,868	waiting times for next routine appointment, at the Regional Perinatal Center, for patients with Gestational Diabetes by 1.5 days. **Metric 1 [I-30.1]:** Next routine appointment of more than X calendar days. **Data source:** Appointment scheduling system **Milestone Incentive Payment:** $438,200
Year 2 Estimated Milestone Bundle Amount: $992,701	Year 3 Estimated Milestone Bundle Amount: $1,074,453	Year 4 Estimated Milestone Bundle Amount: $1,067,737	Year 5 Estimated Milestone Bundle Amount:$876,399
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 4,011,289			

Identifying Information:
Title of Project: Expand specialty care capacity through the development of a women's health care clinic.
RHP Project Identification Number: 112711003.1.5
Reference Number of Project Option Planning Protocol: 1.9.2
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): This project will develop a clinic geared toward Woman's Health, and will include digital mammography screenings, bone density tests, health/fitness classes, and stereotactic biopsies procedures. The goal of this project will offer woman the opportunity to receive comprehensive services all in one location.

- Need for the project: The current Ector County Profile provided by the health department has identified the female population as having a higher rate of potentially preventable hospitalizations in several categories. The needs assessment also states that 35% of the woman 40 years and older in RHP 14 have not received a mammography within the last two years, which is above the National (25%) and Texas (30%) percentages. Through creation of a Woman's Health Clinic, ORMC will help reduce the disparity of care by offering services tailored for the population.

- Target population: Woman in RHP 14 will be able to be served through our Woman's Clinic. Currently 35% of the patients ORMC serves are considered indigent or covered under Medicaid. ORMC expects this program to impact the region's low-income population.

- Category 1 or 2 expected patient benefits: The Woman's Center will allow more patients to have access to services they might otherwise not have. ORMC has a goal of increasing patients seen in the clinic by 15% compared to baseline year.

- Category 3 outcomes: IT-12.5 - Other USPSTF endorsed screening outcome measure - Increase access to care as evidenced through the increase in United States Preventive Services Task Force endorsed screenings, including:
    - Breast Cancer Screenings (Mammography)
    - Osteoporosis Screenings (Bone Density)
    - Dietary Counseling

Project Description:

The women's health clinic will encompass an extensive array of services tailored to woman, focusing on evidenced based-care measures for conditions in which woman are uniquely affected, disproportionately impacted, and conditions that present themselves differently compared to men. ORMC will identify a location for the new clinic, equip the new clinic space, recruit and train providers for the clinic, engage stakeholders, educate the community, and improve overall health outcomes for women.

ORMC will accomplish each of the core requirements of this project: (1) Increase service availability with extended hours (there are currently no hours because there is no women's clinic); (2) increase number of specialty clinic locations (this will be a new clinic in the area to serve the women of the community); (3) the clinic will set up a standardized methodology for making referrals to other specialists in the community, and will track these referrals; and (4) ORMC will perform quality improvement by assessing the impact of the new clinic on the health outcomes of women in the community.

Project Goal(s) and Relationship with Regional Goals:

Expand the capacity of specialty care through a clinic specifically tailored for women's health to better accommodate the needs of this patient population and community so that patients can receive the right care, at the right time, in the right setting.

Through the development of this clinic, ORMC will: increase visits for woman, increase screenings in bone density and mammograms, and increase the amount of dietary consults. The following regional goals will also be addressed: access to primary care (CN1), access to specialty care (CN3), access to women's health services (CN8), and the enhancement of the patient experience (CN19).

Challenges/Issues Faced By Provider:

- Identification of space for the women's health clinic
- Staffing to meet clinic needs
- Identification of services essential for woman's health
- Follow up care for patients that do not have a primary physician
- Financial support for those that cannot afford the costs

5-year Expected Outcome:
Population of woman in region will have better access to care, leading to early diagnosis of preventable diseases, better management of chronic conditions, and collaboration amongst providers.
Based on previous years, ORMC expects to have the following impact:

- Year 2: 2,400 patients served with 1680 being Medicaid/indegent
- Year 3: 2,592 patients served with 1,814 being Medicaid/indigent
- Year 4: 2,688 patients served with 1,881 being Medicaid/indigent
- Year 5: 2,760 patients served with 1,932 being Medicaid/indigent
- Total amount of patients served is expected to be approximately 8,040.

- *ORMC will use DY 3 in order to establish a true baseline that will be used to expand upon during the remaining demonstration years.

Starting Point/Baseline:

There is not currently a clinic in the community dedicated exclusively to women's health. The baseline will be established within year 2 and will increase by a total of 15% by DY5. ORMC expects encounters to be high during the establishment of its baseline within year 2 due to community marketing efforts and community demand.

Rationale:

RHP 14 has had a higher percentage of patients who are unable to access primary care due to the high cost, as compare to the Texas average from 2007-2010. Access to affordable care has been an issue within the region, leading to poor health outcomes and a high percentage of preventable hospitalizations. In addition, access to primary care has become increasingly difficult within the region, resulting in poor overall management of the population's health. RHP 14 has higher death rates than the Texas average in: heart disease, chronic lower respiratory disease, influenza/pneumonia, and cancers of colon, rectum, and anus. With 61 primary care providers per 100,000 people, RHP 14 ranks below the Texas average of 70 per 100,000 resulting in a lack of access to management of care. This issue will only continue as the population increases at its current rate. Improving access to primary care will decrease misuse of the ED and lower healthcare costs. Across the state of Texas, ED visits increased by 28.6% with RHP 14 following this trend.

According the Ector County Profile, provided by the Texas Department of State Health Services, the female population had a higher rate of potentially preventable hospitalizations in: angina, asthma, bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disorder, dehydration, diabetes, hypertension, and urinary tract infections. The development of a women's health clinic, tailored towards these conditions, for the female population is essential if these rates are going to be

reduced. It is well known that the national supply of primary care does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHP 14 is in real need of expanding primary care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care, at the right time, and in the right setting for all patients. Establishing a mechanism for timely, affordable care would lead to improved outcomes and would provide patients with education on how to manage their condition. Additionally, routine preventative medicine services will improve the overall health of the populations served in this area of Texas.

Project Components: Through the establishment of a Women's Health Clinic, ORMC will meet the following project components:

a) *Identify location of clinic space for development of Women's Health Clinic*. Adequate space will need to be identified for implementation of the clinic. The space will need to be outfitted for the specialty equipment that will be installed, including: digital mammography and bone density machine. Space will also need to be considered for the dietary education classes that will take place as well.

b) *Installation of all specialty equipment.* Once space has been identified and modified, the equipment will need to be delivered and installed. The specialty equipment consists of a digital mammography and bone density machine.

Relationship to Category 3 Outcome(s): [IT-12.5] Other USPSTF-endorsed screening outcome measures, including three United States Preventive Services Task Force endorsed screenings, including:

- Breast Cancer Screenings (Mammography)
- Osteoporosis Screenings (Bone Density)
- Dietary Counseling

Relationship to Other Projects:

The development of a Woman's Specialty Clinic would inter-relate to the following projects: Expansion of chronic care management models, the redesign of the patient experience, implementation of evidence-based health promotion and disease prevention programs, and a decrease in readmissions to the hospital.

This project relates to the following Category 4 Reporting Domains because it seeks to provide increased access to primary and specialty care (through treatment and referrals): RD 4 (Patient centered healthcare).

Relationship to other Providers' project within the RHP:

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks to provide additional providers and care tailored to women's primary and specialty health needs, and women make up at least half of the population of the community, so the project will have a broad impact. Additionally, the project should reduce systematic costs of providing care to uninsured and indigent women, as they will have access to primary and preventative care before their conditions become acute and require hospitalization. Finally, this project will take a considerable investment of time, effort, resources, planning, and maintenance. Thus, the overall value of this clinic is high.

112711003.1.5	***1.9***	***Improve access to specialty care 1.9.2***	***Expand specialty care capacity through the development of a women's health care clinic.***
Odessa Regional Medical Center		***112711003***	
Category 3 Outcome Measure(s):	***112711003.3.7***	***IT-12.5***	***Increase number of USPTF preventive screenings toward specific population***
Process Milestone 1 [P-11]: Launch/expand a specialty care clinic ORMC will launch a women's specialty clinic in the community, providing additional hours and space dedicated to women's health care. Metric 1 [P-11.1]: Establish the clinic. Projected Impact: 2,400 patients with 1,680 covered under Medicaid/indigent Data source: documentation of new clinic Process Milestone 1 Incentive Payment: $496,351 Process Milestone 2 [P-X]: Develop baseline for specialty care clinic volume to show evidence of improved access for	Improvement Milestone 1 [I-23]: ORMC will increase the women's health clinic volume by a combined total of 8% over the baseline, providing evidence of increased access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Projected Impact: 2,592 patients with 1,814 covered under Medicaid/indigent Data Source: Registry, EHR Improvement Milestone 1 Incentive Payment: $537,228 Process Milestone 3 [P-X]:Conduct two team based Plan-Do-Study Act workshop within clinics to	Improvement Milestone 2 [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. ORMC will increase the women's health clinic volume by a combined total of 12% over the baseline, providing evidence of increased access for patients seeking services. (I-23) Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). (I-23.1) Projected Impact: 2,688 patients with 1,881 covered under Medicaid/indigent Data source: EHR and/or Registry Improvement Milestone 2 Incentive Payment: $533,869 Improvement Milestone 3 [I-25]: Increase the number of referrals for the most impacted specialties that are reviewed and assigned into appropriate	Improvement Milestone 4 [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. ORMC will increase women's health clinic volume by a combined total of 15% over the baseline, providing evidence of increased access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Projected Impact: 2,760 patients with 1,932 covered under Medicaid/indigent Data source: EHR and/or Registry Improvement Milestone 4 Incentive Payment: $438,200 Process Milestone 4 [P-X]: Assess efficacy of processes in place and recommend process improvements to

patients seeking services. ORMC will increase primary care women's health clinic volume in subsequent years providing evidence of increased access for patients seeking services. Metric 1 [P-X.1] Number of encounters. Data source: EHR and/or Registry Process Milestone 2 Incentive Payment: $496,350	determine process improvement to be undertaken to increase efficiency Metric 1 [P-X.1]: Process improvement recommendations Data source: Plan Documentation Process Milestone 3 Incentive Payment: $537,228	categories. The clinic will track and increase referrals to other providers in the community. Metric 1[I-25.1]: Proportion of referrals appropriately categorized Data source: referral management system Improvement Milestone 3 Incentive Payment: $533,868	implement, if any. Metric 1 [P-X.1]: Report detailing successes and lessons learned by implementing the women's clinic, and strategies for improvement. Data source: Efficacy Report Process Milestone 4 Incentive Payment: $438,199
Year 2 Estimated Milestone Bundle Amount: $992,701	Year 3 Estimated Milestone Bundle Amount: $1,074,453	Year 4 Estimated Milestone Bundle Amount: $1,067,737	Year 5 Estimated Milestone Bundle Amount:$876,399
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 4,011,289			

Identifying Project and Provider Information:
Project Title/Option: Expand Specialty Care Capacity 1.9.2
Unique Category 1 Identifier: 138364812 1.1
Performing Provider: Permian Basin Community Centers (PBCC)/138364812

Summary Information

Provider: Permian Basin Community Centers (PBCC) is one of 39 community centers in the state that contracts with DSHS as the Local Mental Health Authority. Its service area covers 6 counties in RHP 14 with a total population of 292,488, 92% of which are in Midland and Ector counties. It also covers two other counties included in two other RHP's.

Intervention: This project will expand the provider network of psychiatrists and licensed behavioral therapists to provide services to individuals who do not currently have access to those services. This will be accomplished through either on-site providers or through telemedicine.

Target Population: DSHS primarily funds only services to individuals with a diagnosis of Bipolar, Major Depression or Schizophrenia. Of those served by PBCC, 34% are Medicaid eligible and 44% are indigent. This project would serve individuals with mental health disorders besides those just listed, and who have limited access to community providers because of the same issue of Medicaid eligibility or indigent status.

Need for Project: Behavioral health services for Medicaid eligible or indigent individuals is limited in RHP 14 due to shortages of licensed providers willing to serve these individuals at the Medicaid rate or without other funding.

Category 1 expected benefits: This project intends to provide Behavioral Health services to approximately 323 persons not currently receiving those services.

Category 3 outcomes: 3.IT.6.1 goal is improve Patient Satisfaction by 40% over a baseline to be established.

Project Description:

PBCC intends to increase the capacity to provide specialty care services, e.g., Behavioral Health Care capacity, primarily psychiatric and counseling services, to patients with psychiatric diagnoses such as anxiety, depressive, adjustment, obsessive compulsive and post-traumatic stress disorders who are primarily indigent or Medicaid eligible.

Currently, PBCC receives its mental health funding from the Department of State Health Services (DSHS), which allows funding only for "target" diagnoses, i.e. serous and persistent mental illness diagnoses of schizophrenia, bipolar disorder and major depression. This leaves a large gap in specialty services and weakens the safety net system for mental health. The current client base of PBCC is 34% Medicaid eligible and 44% indigent.

PBCC intends to open two new mental health clinics – one in Midland and one in Odessa – to provide mental health services to this segment of the population that is currently not being served by the public mental health system due to restricted eligibility criteria.

These clinics will be leased and equipped appropriately in locations yet to be determined. A psychiatrist and nurse will be recruited for each clinic as well as a licensed counselor. A qualified mental health professional will be hired as case manager.

The primary challenge for PBCC will be recruiting, hiring (or contracting with), and training licensed staff to provide services in this rural area of West Texas. The clinic hours will depend on the availability of the psychiatrists and licensed counselors, who may either provide services face-to-face or via telemedicine. Ideally, the hours of operation will be flexible to provide increased hours of access to working clients.

The goal of this project by the end of DY 5, is to have increased the availability of behavioral health services to 323 new individuals who would not have previously had access to treatment for mental health conditions either from primary care providers or otherwise, thereby increasing patient satisfaction. This will be achieved gradually by reaching a goal of 32 new patients in DY 3 and 161 new patients in DY 4. A customizable Process Milestone will be used in DY 2: that of developing the project plan and timelines for opening 2 new clinics that will detail staff and recruitment needs, clinic space acquisition, training materials, development of protocols, etc. This milestone best reflects the tremendous amount of planning needed to ensure the success of this project.

Individuals suffering from non-target population diagnoses are forced to go without treatment due to a shortage of specialty care providers or behavioral health providers in a primary care setting. Left untreated, these patients' symptoms worsen, leading to utilization of costly local emergency department treatment, utilization of hospital district funded contract beds with private for profit inpatient psychiatric facilities, and/or inpatient State Mental Health Facility (SMHF) resources. PBCC receives no federal funds for any similar project.

Continuous Quality Improvement (CQI) is a concept that is fully integrated into PBCC operations as outlined in its Quality Management (QM) Plan, and implemented by 3 full-time QM Coordinators. The QM staff will conduct regular meetings with the IT, Fiscal and Data Management staff to develop plans, reports, project data etc. to inform the process of Plan, Do, Study, Act. These CQI activities are reflected as milestones in the attached tables. A customizable Process Milestone for these efforts will be a milestone in DY 2-4 and is consistent with CQI efforts for other proposed projects and current practice.

Protocols will be developed to ensure that providers have access to reports of utilization of services and healthcare outcomes. These reports will be reviewed at the already regularly scheduled meetings of PBCC's Utilization Management Committee that includes the PBCC Medical Director.

Starting Point/Baseline:

PBCC currently turns away approximately 32% of individuals screened for Behavioral Health services at the time of screening due to individuals not meeting the strict target population diagnostic criteria promulgated by DSHS; however, the majority of these individuals do suffer from mental health disorders, and would benefit from treatment of those disorders. PBCC conducts an average of 1,261 screenings annually. As stated, approximately 32% of those persons screened do not meet

DSHS diagnostic criteria, and 80% of those are conservatively estimated to have mental health disorders. PBCC is unable to provide any services to them at this time.

Insufficient state funding for non-target diagnosis population, lack of available specialty care providers in PBCC's catchment area, especially for the indigent care population, and a rapidly expanding population as a result of the strength of the local oil economy are all factors that exacerbate the access barriers for people suffering from mental illness in the Permian Basin.

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.

With regard to specialty areas of greatest need, the recent report of the Committee on Physician Distribution and Health Care Access cites psychiatry, general/preventive medicine, and child and adolescent psychiatry where the ratios per 100,000 populations are 56.7%, 60.2% and 67% of the U.S. ratios, respectively.

Low reimbursement rates and administrative burdens are driving physicians away from Medicaid and Medicare patients in Texas according to findings from a recent Texas Medical Association survey. According to results from the recent survey of more than 1,000 Texas physicians, thirty-one percent currently accept Medicaid patients; that is down from 42 percent in 2010. Texas physicians are also cutting back on Medicare patients. According to the biennial survey, the percentage of physicians in the state accepting new Medicare patients dropped from 66 percent in 2010 to 58 percent this year. (Becker's Hospital Review, "Fewer Physicians Accepting Medicare, Medicaid Patients", July 09, 2012).

The supply of behavioral health care providers is inadequate in most of the State. In April of 2011, 195 (77%) of Texas' 254 counties held federal designations as a whole county Health Provider Shortage Areas (HPSA) ("Highlights: The Supply of Mental Health Professionals in Texas – 2010", Texas Department of State Health Services Center for Health Statistics, E-Publication No. E25-12347. Accessed at http://www.dshs.state.tx.us/chs/hprc/publicat.shtm).

State funding for behavioral health indigents is limited. Texas ranks 50th in per capita funding for state mental health authority (DSHS) services and supports for individuals with mental health and substance use disorders. Medically indigent individuals who are not eligible for Medicaid have little or no access to needed services. When access is available, the indigent person may have to wait for extended periods of time. Texas ranks highest among states in the number of uninsured individuals per capita. People with behavioral health disorders are disproportionately affected. For example, 60 percent of mentally ill adults served in the public system are uninsured (DSHS Decision Support, 2012).

Community-based services, which include medication, case management and therapies, also offer the most cost effective care. Health Management Associates' research shows that the average cost per day of community based care is $12, compared to $986 for an emergency department visit. Moreover, a headline-making study by the Integrated Care Collaboration and co-authored by Ziebell showed how nine patients using the emergency department over a six year period cost three million dollars to treat. Seven of those patients suffered from mental illness. Those seven patients had fallen-expensively – through the net. (Texas Hospitals, May/June 2012, "Nowhere Else to Go – Texas' underfunded mental health system shifts a costly burden to emergency rooms").

Time Magazine published "Tallying Mental Illness' Costs" by Kathleen Kingsbury , May 09, 2008 and stated the following: "More than one in four American adults suffers from shorter-term,

but clinically diagnosable mental disorders in a given year – including depression or an eating disorder – and such disorders are the leading cause of disability among U.S. workers under age 45."

The County Health Rankings for Midland and Ector County reflect that, for "Poor Mental Health Days", Ector County residents experience 4.1 days and Midland County residents experience 2.7 days, compared to the national average of 2.3 days (www.countyhealthrankings.org/print/county/snapshots/2012/48/135).

According to the Mentor Research Institute in its January 17, 2007 article "The Impact of Untreated Mental Health Problems on Medical Care", "at least 50% of all unnecessary medical care is sought by people with untreated mental disorders."

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. **See Attachment 4 in Addendum.**

As described above, this project addresses the following Community Needs Assessment items
Number CN.2 High costs associated with preventable hospitalization admissions and readmissions.
Number CN.3 Shortages of health care professionals, including primary care physicians and mental health care providers.
Number CN.6 Need to overcome patient access to care barriers

* *PBCC intends to fulfill core components a-d identified in project option 1.1 of the planning protocol.*

Related Category 3 Outcome Measures:

This project is related to Category 3, OD-6, "Patient Satisfaction". Patient satisfaction surveys are designed to produce comparable data on the patients' perspectives of care that allows for objective and meaningful comparisons between institutions on domains that are important to individuals. Public reporting and sharing of survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

A recent study reported the association between patient satisfaction and mortality rates after adjusting for clinical quality. Higher patient satisfaction was associated with lower mortality even after controlling for adherence to evidence-based practice guidelines, demonstrating that patients can judge the quality of clinical care they receive. Patient satisfaction is not about making patients "happy". It is about improving the patients experience to facilitate health and medical outcomes. When patients are satisfied, trust is enhanced. When patients trust their physician, they are more likely to disclose information, follow advice and adhere to treatment plans. Improving patient satisfaction also helps to ensure that people don't avoid getting the care they need which could prevent larger health issues in the future. (Press Ganey, "How Patient Satisfaction Correlates with Clinical Quality" by Maxwell Drain, MA, April 12, 2010).

As explained in paragraph three above for the rationale for this project the individuals that will benefit from this project are historically indigent or underfunded (i.e. Medicaid), and would not have access to these services and outcomes withstanding funds available through the 1115 waiver.

Relationship to other Projects:

The expansion of behavioral health specialty services will be expanded via utilization of technology and expansion of available capacity. The following category projects relate: Category 1.7, 1.10, 1.11, 1.12.

Process improvement and case management will be essential in improving patient experience, and providing successful interventions for the targeted behavioral health population. The following category projects relate: Category 2.4, 2.8, 2.13, 2.19

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 intends to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Permian Basin Community Centers (PBCC) proposes to increase Behavioral Health Care capacity, primarily psychiatric and counseling services, to individuals who do not currently qualify for eligibility for Department of State Health Services (DSHS) funding.

The following valuation is based on work prepared by H. Shelton Brown, Ph.D., A. Hasanat Alamgir, Ph.D., UT Houston School of Public Health and Thomas Bohman, Ph.D., UT Austin Center for Social Work Research.

It uses the method of cost-utility analysis (a type of cost-effectiveness research), as well as additional information on potential future costs saved. See Addendum 4– Rationale for Economic Valuation.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The number of life-years added is based on a review of the scientific literature.

Since integrated healthcare is synonymous with collaborative healthcare, the term "collaborative healthcare" will be used in this valuation to be consistent with the literature referenced.

Cost-Utility Analysis:

One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.018 incremental life years gained. After quality-adjusting, .335 quality–adjusted life-years were added. Assuming the program would serve 323 persons in a year, the following formula shows the total valuation:

323 (persons served)
x 0.335 (QALY gained)
x $50,000 (life year value)
= $5,410,250
x 4 (years)
= $21,641,000

Cost-Effectiveness and Cost Savings: Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. Simon et al. (2012) found that collaborative care yielded 47.7 additional depression-free days per year at a cost of $52 per depression-free day. Based on this CEA,

323 (persons served)
X 47.7 (depression-free days)
X $52
= $801,169
X 4 (years)
= $3,204,677

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. (See Addendum 4). Based on RHP 14's average hospital cost of $18,852 (Addendum 4), the cost savings would be:

323 persons served x $18,852 = $6,089,196 annually or $24,356,784

Summary and Total Valuation:

This valuation analysis shows that the intervention will have a positive value for participants who receive the interventions. The total valuation is between $21,641,000 and $24,356,784, but no less than the $4,012,720 projected value. There is additional supporting evidence that the intervention will lead to increased depression-free days.

References:

Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch. Gen Psychiatry, 69(5),* 506-514.

Simon, G. E., Manning, W. G., Katzelnick, D. J., Pearson, S. D., Henk, H. J., & Helstad, C. S. (2001). Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. *Arch Gen Psychiatry, 58(2),* 181-187

138364812.1.1	1.9.2	1.9.2.A,B,C,D	EXPAND SPECIALTY CARE CAPACITY	
Permian Basin Community Centers (PBCC)				*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.1	*3-IT-6.1*	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-X) Develop a project plan for establishment of two new behavioral health clinics Metric 1: **(P-X.1)** Documentation of plan and timeline detailing operational and staff needs, recruitment efforts, clinic space acquisition, training materials and equipment Goal: Complete project plan Data Source: Project Plan Milestone 1 Estimated Incentive Payment*):* $383,206 **Milestone 2**: **(P-X)** Evaluate and continuously improve services. Metric 1 **(P-X.1)** Project planning and implementation documentation demonstrate plan, do, study, act quality improvement cycles. Goal: N/A (QI Milestone) Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement Milestone 2 Estimated Incentive Payment: $383,207	**Milestone 3:** (P-11) Launch new specialty care clinics – behavioral health **Metric 1: (P-11.1)** Establish new behavioral health clinics Goal: Two new clinics are providing services to 10% of non-target referral patients -32 patients Data Source: Documentation of two established clinics providing services Milestone 3 Estimated Incentive Payment: $518,700 **Milestone 4**: **(P-X)** Evaluate and continuously improve services. Metric 1 **(P-X.1)** Project planning and implementation documentation demonstrate plan, do, study, act quality improvement cycles. Goal: N/A (QI Milestone) Data Source: Project reports including examples of how real-time data is used		**Milestone 5: (I-23)** Increase Behavioral Health 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. Demonstrate improvement over prior reporting period. Goal: Increase number of patients to 161 patients Data Source: Registry, EHR, claims, encounters or other Performing Provider Source Milestone 5 Estimated Incentive Payment: $559,898 **Milestone 6: (P-X)** Evaluate and continuously improve services Metric 1 **(P-X.1)** Project planning and implementation documentation demonstrate plan, do, study, act quality improvement cycles.	**Milestone7**: **(I-23)** Increase Behavioral Health 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. Demonstrate improvement over prior reporting period. Goal: Increase number of unique patients to 323 Data Source: Registry, EHR, claims, encounters or other Performing Provider Source Milestone 7 Estimated Incentive Payment: $544,555 **Milestone 8: (P-X)** Evaluate and continuously improve services Metric 1 **(P-X.1)** Project planning and implementation documentation demonstrate plan, do, study, act quality improvement cycles.

138364812.1.1	1.9.2	1.9.2.A,B,C,D	EXPAND SPECIALTY CARE CAPACITY	
Permian Basin Community Centers (PBCC)				*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.1	*3-IT-6.1*	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)**
	for rapid cycle improvement Milestone 4 Estimated Incentive Payment: $518,701		Goal: N/A (QI Milestone) Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement Milestone 6 Estimated Incentive Payment: $559,898	Goal: N/A (QI Milestone) Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement Milestone 8 Estimated Incentive Payment: $544,555
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $766,413	Year 3 Estimated Milestone Bundle Amount: $1,037,401		Year 4 Estimated Milestone Bundle Amount: $1,119,796	Year 5 Estimated Milestone Bundle Amount: $1,089,110
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,012,720				

Identifying Project and Provider Information:
Project Title and Option: Enhance Service Availability to Appropriate Levels of Behavioral Health Care Project Option 1.12.4
Unique Category 1 Identifier: 138364812.1.2
Performing Provider: Permian Basin Community Centers (PBCC)/138364812

Summary Information

Provider: Permian Basin Community Centers (PBCC) is one of 39 community centers in the state that contracts with DSHS as the Local Mental Health Authority. Its service area covers 6 counties in RHP 14 with a total population of 292,488, 92% of which are in Midland and Ector counties. It also covers two other counties included in two other RHP's. It is also licensed by DSHS for inpatient and outpatient substance abuse treatment.

Intervention: This project intends to expand the capacity of its existing detox and residential substance abuse facility from 22 beds to 42 beds, and increase access to 24/7 admission availability.

Target Population: This project will serve indigent, low-income and Medicaid eligible individuals who currently have no access to substance abuse treatment due to the shortage of beds/providers in RHP 14.

Need for Project: Substance abuse treatment in the Permian Basin is extremely limited at a time when the local oil economy boom is attracting unprecedented numbers of people to this area hoping to find employment. Untreated, substance abuse leads to a high rate of potentially preventable hospitalizations in part due to the high rates of chronic disease among this population. PBCC is currently the only provider of indigent Inpatient Residential Treatment (IRT) and detoxification services in central west Texas. The treatment options for indigent patients for individuals residing in central west Texas are approximately 120 miles from Midland, Texas.

Category 1 expected benefits: This project intends to provide detox and intensive residential services to approximately 240 additional persons annually by DY5.

Category 3 outcomes: 3.IT.10.1 goal is improve Quality of Life by an amount to be determined in DY 3.

Project Description:

PBCC intends to increase the capacity of its detox and residential substance abuse facility from 22 to 42 beds. The goal of this project is to enhance access to intensive residential treatment and detoxification services, while reducing the need for local Emergency Departments (ED) in PBCC's catchment area to purchase expensive mental health and detox beds for crisis like situations that are substance abuse related. PBCC could treat these persons in a less restrictive environment and increase their quality of life. The existing inpatient facility is already licensed for 42 beds. The goal in DY 4 is to serve 30% more patients than the current baseline of 402, or 120 additional patients, and by DY 5 to be serving 60% more individuals over the baseline or 240 additional patients. A customizable Improvement Milestone reflects this goal in DY 4 and DY 5.

PBCC will implement a medical model for inpatient substance abuse treatment that will allow for direct patient admittance to its residential treatment facility 24 hours per day, 365 days per year. PBCC will collaborate with hospital districts, private providers, and tele-health providers to secure a pool of qualified medical personnel to ensure increased access. It is the performing provider's expectation that this model will increase access for patients in RHP 14, reduce the need for utilization of local EDs, and provide an alternate and more expedient option for law enforcement when law enforcement encounters individuals in the community suffering from substance abuse disorders and/or comorbid behavioral health disorders.

The program will be designed to accept individuals for detox and/or intensive residential substance abuse treatment. The expectant average length of stay for a detox patient will be between 3 and 5 days, after which qualifying individuals will be eligible for up to 45 days of intensive inpatient residential treatment. The program will also be designed to interface with PBCC's outpatient mental health clinics to ensure that all behavioral health issues are treated in the most therapeutic manner possible. PBCC's inpatient substance abuse facility will also work closely with its Mobile Crisis Outreach Teams (MCOTS) in an effort to ensure that acute mental health crises are dealt with in a safe and expedient manner. PBCC's MCOTs operate 24 hours per day, 7 days per week, and 365 days per year.

Continuous Quality Improvement (CQI) is a concept that is fully integrated into PBCC operations as outlined in its Quality Management (QM) Plan, and implemented by 3 full time QM Coordinators. It is the intent of PBCC to conduct regular meetings between the Data Management Coordinator, IT, Fiscal and Direct Care Staff to develop plans, reports, etc. for the Plan, Do, Study, Act steps of rapid cycle change theory. Utilization management reports of length of stay, rates of completion, waiting lists, etc. will be generated and reviewed on a regular basis. These activities are reflected as Milestones in DY 2 – 4.

The primary challenge for PBCC will be recruiting, hiring (or contracting with), and training licensed staff to provide services in this rural area of West Texas who may either provide services face-to-face or via telemedicine.

Starting Point/Baseline:

PBCC is currently funded for 22 substance abuse treatment beds. This level of funding is insufficient to meet the needs of the communities in RHP 14. PBCC is currently the only provider of indigent Inpatient Residential Treatment (IRT) and detoxification services in central west Texas. The closest residential treatment options for indigent patients for individuals residing in central west Texas are approximately 320 miles from Midland, Texas. Despite securing additional funds to supplement DSHS substance abuse funding in FY 12, PBCC exhausted its available funding resources, and was forced to greatly reduce admissions months before the end of FY 12. Less than .1% of the current program's costs are funded by self-pay clients or those with insurance.

Rationale:

The Permian Basin has experienced multiple funding reductions for Substance Abuse programs since the 1990's while, at the same time, the population has increased significantly due to persons moving to the area seeking employment in the booming oil economy.

The current program is partially funded by U.S. Department of Health and Human Services block grants passed through the Texas Department of State Health Services.

Untreated mental illnesses and substance use disorders increase state spending in other areas including: emergency rooms, hospitals, jails, prisons, and detention centers. A lack of spending on substance use disorder treatment accounts for 81% of the $51.3 billion in spending by all 50 states and D.C. for justice-related programs in adult corrections, juvenile justice, and the judiciary. It also accounts for almost one third (28%) of the $130.1 billion in total state spending on healthcare, which is primarily composed of Medicaid spending but also includes other general assistance medical care spending. (The National Council for Community Behavioral Healthcare, *The Spill Over Effect of Untreated Mental Illnesses and Substance Abuse Disorders on State Budgets,* http://www.namitexas.org/homecontent/Spill Over EffectonStateBudgets.pdf

The conclusion of a study measuring the impact of substance use disorders on Medicaid expenditures for behavioral and physical health care was that the impact of addiction on Medicaid populations was greater than the cost of treatment. In the six states studied, $104million more was spent on medical care and $105.5 million more on Behavioral Health care delivered to individuals with substance use diagnosis than for care given to persons with other behavioral health disorders but no substance use diagnosis (ps.psychiatryonline.org/article.aspx?articleid=100064).
For each additional dollar invested in addiction treatment, tax payers save at least $7.46 in costs to society. (The National Council for Community Behavioral Healthcare (2007). *The Uninsured: The Impact of Covering Mental Illness and Addictions Disorders.)*
http://www.thenationalcouncil.org/galleries/policy-file/CoveringTheUninsured.pdf

According to the Office of National Drug Control Policy, health care costs attributable to drug abuse totaled $15.8 billion in 2002. (Office of National Drug Control Policy, 2004, *The economic costs of drug abuse in the United States, 1992-2002.* Washington, DC: Executive Office of the President (Publication No. 207303) Page ix.
www.whitehousedrugpolicy.gov/publications/economic_costs/economic_costs.pdf).

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. **See Addendum 4.**
Other data that points to the degree of unmet needs in this RHP 14 are the Texas County Health Rankings that show "Excessive drinking" reported at 16% for Ector County and 13% for Midland County, compared to the national benchmark of 8%
(www.countyhealthrankings.org/print/county/snapshots/2012/48/135).

Northern California Kaiser Permanente did an analysis of pre and post substance use treatment and associated medical costs. The substance use treatment group had a 39% reduction in emergency room cost, and a 26% reduction in total medical cost compared with the matched control group. (Vision of the Integration Policy Initiative - *Overall Health and Wellness is Embraced as a Shared Community Responsibility,* page 10).

Substance abuse is often a cause of homelessness. Addictive disorders disrupt relationships with family and friends and often cause people to lose their jobs. For people who are already struggling to pay their bills, the onset or exacerbation of an addiction may cause them to lose their housing. A 2008 survey by the United States Conference of Mayors asked 25 cities for their top three causes of homelessness. Substance abuse was the single largest cause of homelessness for single adults (reported by 68% of cities). Substance abuse was also mentioned by 12% of cities as one of the top three causes of homelessness for families. According to Didenko and Pankratz (2007), two-thirds of homeless people report that drugs and/or alcohol were a major reason for their becoming

homeless (National Coalition for the Homeless (July 2009), *Substance Abuse and Homelessness,* http://www.nationalhomeless.org/factsheets/addiction.pdf).

According to the Journal of the American Medical Association, the highest cost in healthcare and public funds are those who are chronically homeless with severe alcohol addiction (301(13), P1349-1357). The homeless suffer from premature death rates as compared with developing countries with a life expectance of 42-52 years. (Larimer, M.E., Malone, D.K. Garner, M.D., Atkins, D.C, Burlingham, B., Longczak, H.S., Tanzer, K., Ginzler, J., Clifasefi, S.L., Hobson, W.G., Marlett, G.A., (2009)). The homeless are 7 times more likely to die over the next 5 years as compared to those who have housing and the same or similar condition. Homeless people stay twice as long in the hospital because they are twice as sick. (Hewlett, N., Halligan, A., (2010), *Homelessness is a healthcare issue,* Journal of the Royal Society of Medicine: 103, p306-307)

As described above, this project addresses the following Community Needs
CN.1 High rates of chronic disease
CN.2 High costs associated with preventable hospitalization admissions and readmissions
CN.6 Need to overcome patient access to care barriers – the closest publicly funded detox facility is over 2 hours away

Related Category 3 Outcome Measure:

This project is related to Category 3, OD-10, "Quality of Life". Although much of health care is focused on increasing longevity, many treatments are specifically designed to improve symptoms and functions, two essential components of health – related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey.

Project planning and conducting Plan Do Study Act (PDSA) are essential in laying the ground work for the development of successful demonstration projects that are designed to operate under continuous improvement monitoring. Data will be collected in simple interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purpose of improvement.

There is evidence that Health Related Quality of Life (HRQOL) predicts outcomes among patients. A study of 1,000 patients at three dialysis facilities in the United States reported an association between lower scores in the physical component of quality of life and higher risk of death and hospitalization.

A larger study, involving 5,256 patients at 243 facilities in the United States and Europe presented evidence that psychological or mental components of quality of life predict death in hemodialysis patients. Self – reported depression was significantly associated with a higher risk of death and hospitalization (Kidney International, "Health Related Quality of Life, as a predictor of mortality and hospitalization: The Dialysis Outcomes Practice and Patterns Study (DOPPS), *Kidney International* (2003) 64, 339–349; doi:10.1046/j.1523-1755.2003.00072). It is PBCC's contention that the same principles apply to behavioral health and other primary care ailments, and that affecting QOL will improve patient outcome and output measures leading to decreased utilization of costly inpatient and emergency medical care.

As explained in paragraphs one of Starting Point/Baseline above for the individuals that will benefit from this project are historically indigent or underfunded (i.e. Medicaid), and would not have access to these services and outcomes without funds available through the 1115 waiver.

Relationship to other Projects:

The expansion of substance abuse services will be dependent upon technology, performance improvement and case management. The following category projects relate: Category 1.7, 1.10, 1.11, 1.12

This project will provide an intervention to prevent unnecessary use of services in EDs and jails while improving the patient experience. The following category projects relate: 2.4, 2.8, and 2.13

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

Plan for Learning Collaborative:

RHP 14 intends to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Permian Basin Community Centers (PBCC) proposes to increase the capacity of its residential substance abuse facility from 22 to 42 beds.

The following valuation is based on work prepared by H. Shelton Brown, Ph.D., A. Hasanat Alamgir, Ph.D., UT Houston School of Public Health, and Thomas Bohman, Ph.D., UT Austin Center for Social Work Research.

It uses the method of cost-utility analysis (a type of cost-effectiveness research), as well as additional information on potential future costs saved.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The number of life-years added is based on a review of the scientific literature. **See Addendum 4 – Rationale for Economic Valuation.**

Cost-Utility Analysis:

Two studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed 0.22 QALYs gained for those receiving treatment. Drummond et al. (2009) looked at alcohol

treatment in a collaborative care setting, and QALYs increased by 0.0027. The average of these two values is 0.11135. Assuming 240 patients enroll in this program, the total value of this component would be:

	240	(persons served)
x	0.11135	(QALY gained)
x	$50,000	(life year value)
=	$1,336,200	(annually)
x	4	(years)
=	$5,344,800	total

Cost effectiveness and Cost Savings:

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. (**See Addendum 4**). Based on RHP 14's average hospital cost of $18,852 (**See Addendum 4**), the cost savings would be:

- 240 persons served x $18,852 = $4,524,480 annually or $18,097,920 for the project duration.

The Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (SAMHSA) states that treatment has been shown to have a benefit cost ratio of 7:1. (https://www.samhsa-gpra.samhsa.gov/CSAT/view/docs/SAIS_GPRA_CostOffsetSubstanceAbuse.pdf).

SAMHSA also states that $487,000 of health care costs are avoided for every $100,000 spent on treatment or a benefit cost ratio of 4.87:1.

Summary and Total Valuation:

This valuation analysis shows that the intervention will have a positive value for participants who receive the interventions. The total valuation is between $5,344,800 and $18,097,920, but no less than the $4,020,192 projected value.

References:

Drummond, C., Coulton, S., James, D., Godfrey, C., Parrott, S., Baxter, J. & Peters, T. (2009). Effectiveness and cost-effectiveness of a stepped care intervention for alcohol use disorders in primary care: pilot study. *Br J Psychiatry, 195(5),* 448-456. doi: 10.1192/bjp.bp.108.056697

Schackman, B., Leff, J., Polsky, D. Moore, B., and Fiellin, D. (2012). Cost-effectiveness of long-term outpatient Buprenorphine-Naloxone treatment for opioid dependence in primary care. *Journal of General Internal Medicine, 27(6),* 669-676. doi: 10.1007/s11606-011-1962

138364812.1.2	1.12.4	N/A	ENHANCE SERVICE AVAILABILITY TO APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE	
Permian Basin Community Centers (PBCC)				*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.2	*3-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 : **(Cat 1, pg. 136, P-2)** Identify licenses, equipment requirements and other components needed to implement and operate options selected Metric 1: **(Cat1, pg. 136, P-2.1)** Develop a project plan and timeline detailing the operational needs, training materials, equipment and components. Baseline /Goal: Complete project plan and establish baselines to determine staffing needs. PBCC's baseline for this project was 402 individuals in FY 12 Data Source: Project Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $318,404 **Milestone 2: (Cat 1, pg. 137, P-7)** Evaluate and continuously improve services Metric 1: **(Cat 1, pg. 137, P-7.1)** Project planning and implementation documentation demonstrates plan,	**Milestone 3**: **(Cat 1, pg. 136, P-4)** Hire and train staff to manage projects selected Metric 1 **(Cat 1, pg. 136, P-4.1)** Number of staff secured and trained Goal: Secure and train staff necessary to begin expansion Data Source: Project records, Training curricula as developed in P-2 Milestone 3 Estimated Incentive Payment: $552,984 **Milestone 4: (Cat 1, pg. 137, P-7)** Evaluate and continuously improve services Metric 1: **(Cat 1, pg. 137, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: N/A (QI Measure) Data Source: Project reports including examples of how real-time data is used for rapid cycle		**Milestone 5** : **(Cat 1, pg. 140,I-X)** Increase volume of individuals served Metric 1: **(Cat 1, pg. 140. I-X)** Documentation of increased volume of individuals over baseline Goal: Increase volume of individuals served by 30% over baseline or 120 additional individuals Data Source: Registry, EHR, Claims Encounters or other sources Milestone 5 Estimated Incentive Payment: $583,176 **Milestone 6: (Cat 1, pg. 137, P7)** Evaluate and continuously improve services Metric 1: **(Cat 1, pg. 137, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: N/A (QI Measure) Data Source: Project reports including examples of how real-time	**Milestone 7: (Cat 1, pg. 140,I-X)** Increase volume of individuals served Metric 1: **(Cat 1, pg. 140. I-X)** Documentation of increased volume of individuals over baseline Goal: Increase volume of individuals served by 60% over baseline or 240 additional individuals Data Source: Registry, EHR, Claims Encounters or other sources Milestone 7 Estimated Incentive Payment: $555,531 **Milestone 8: (Cat 1, pg. 137, P-7)** Evaluate and continuously improve services Metric 1: **(Cat 1, pg. 137, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: N/A (QI Measure)

138364812.1.2	1.12.4	N/A	ENHANCE SERVICE AVAILABILITY TO APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE	
Permian Basin Community Centers (PBCC)				*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.2	*3-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)**
do, study, act quality improvement cycles Baseline/Goal: N/A (QI Measure) Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 2 Estimated Incentive Payment *(maximum amount):* $318,405	improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 4 Estimated Incentive Payment *(maximum amount):* $552,984		data is used for rapid cycle improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 6 Estimated Incentive Payment *(maximum amount):* $583,176	Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 8 Estimated Incentive Payment *(maximum amount):* $555,532
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $636,809	Year 3 Estimated Milestone Bundle Amount: $1,105,968		Year 4 Estimated Milestone Bundle Amount: $1,166,352	Year 5 Estimated Milestone Bundle Amount: $1,111,063
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,020,192				

Identifying Information
Project Title: West Texas Center RHP 14 Telemedicine Expansions (Project Option 1.11.3)
RHP Project Number: 130725806.1.1
RHP Performing Provider: West Texas Centers
TPI: 130725806

Summary Information:
Provider: West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended. The Center began operations on March 1, 1997 and continues to serve as the designated local authority for mental health and intellectual and developmental disabilities through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in ten counties in the RHP 14 area. West Texas Centers operates mental health clinics in seven of these ten extremely rural counties. All counties within the project are designated Federal health professional shortage areas.

Intervention: This project will enable WTC to purchase and install additional equipment to increase the capacity of our current telemedicine network. Increased infrastructure will occur in five of the RHP 14 counties where WTC operates mental health clinics as well as the HUB site in Howard County. Additional broadband, hardware and software will provide additional hours of provider time to consumers in these counties/clinics. Additional provider availability will be established one the hardware infrastructure to expand the telemedicine network has been completed. This will increase physician availability across the very rural area, decreasing appointment wait times and inappropriate law enforcement incarcerations and emergency room admissions. This project will be an expansion of West Texas Centers' current telemedicine network.

Need for the Project: Current wait times for appointments in these areas are from 15 to over 30 days, with physician clinics scheduled only weekly or even less often due to the lack of telemedicine infrastructure. Delays in obtaining psychiatric appointments often result in consumers experiencing preventable crisis situations, which frequently require costly hospitalizations. Telemedicine is the only mechanism available in most cases to provide behavioral health care to this large geographic area. Once the network expansion has occurred additional physician and nursing hours can be procured which will increase available appointments and decrease consumer wait times. This project will increase current psychiatrist appointments to over 4500 annually to an average patient census of over 850 people.

Target Population: West Texas Center's patient population is 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years and it is estimated this percentage will be similar throughout the project.

Category 1 expected patient benefits: West Texas Centers currently provides physicians behavioral health care services to approximately **850** persons in RHP 14. It is expected by DY 4

this project will increase the number of WTC telemedicine visits to persons in RHP 14 to over 4500 annually. By DY 5 all RHP 14 all patients in physician services at WTC will see appointment waiting times reduced from the average of 22 days to seven days or less.

Category 3 outcomes: : West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement measure IT-6-1: Percent Improvement over baseline of patient satisfaction scores with standalone measure (1) patients are getting timely care, appointments, and information. During DY3, the process measure to develop and test systems will include selection of the patient satisfaction survey instrument and actual conducting of the baseline survey. DY 4 and DY5 will require 25% and 40% improvement respectively in the improvement measure as measured by the patient satisfaction survey instrument.

Project Description:

West Texas Centers will expand access to behavioral health care through expansion of our current telemedicine network in Andrews, Howard, Reeves, Upton, Ward and Winkler Counties. All West Texas Center Counties in the RHP are served primarily via a current telemedicine system from the hub site of Big Spring, Texas. Acquisition of additional broadband capacity, hardware, software, office space, support staff and expansion of existing professional personnel contracts will provide increased access to care for consumers. Goals will include reduced patient wait times, decreased times for emergency departments and law enforcement personnel to be involved in crisis response activities. The overall project will increase access to behavioral health care services in these locations by 10% over current capacity by the end of demonstration year 5. This project relates to RHP 14 goals of improving overall healthcare access in the region by expanding access to behavioral health care services.

Challenges will include continued difficulty in recruitment of professionals and paraprofessionals to this very rural area. To meet this challenge expansion of current West Texas Center's professional contracts will enable faster project development during DY 3, while ongoing employment type recruitment activities continue through DY 4 and 5. An additional challenge will include procurement times associated with broadband expansion, as providers of these services are currently close to capacity due to the exceptionally robust economy in the West Texas area. West Texas Centers enjoys long time relationships with technological providers in the area which should assist in meeting broadband acquisitions and achieving some priority in procurement negotiations.

Even with these challenges, West Texas Centers anticipates meeting all core component requirements, milestones and metrics within the project by completion of demonstration year 5.

Starting Point/Baseline:

Baseline encounter data will be obtained from WTC fiscal year 2012 patient records, encounter data and other data relevant to this project. WTC will continue to refine baseline data during DY 2.

Rationale:

RHP 14 Community Needs Assessment numbers CN3 Access to Specialty Care; CN4 Access to Mental Health Providers and CN-19 Enhance Overall Patient Experience will be addressed through this project. West Texas Centers currently operates telemedicine in these counties. Existing technical infrastructure at these locations is inadequate to provide additional needed access to psychiatric assessment and medication management capacity. It was not possible to utilize project option 1.11.1 for this project as this is not an implementation of telemedicine but an expansion which will significantly enhance the existing delivery structure so the decision to create an "other" project was made. This project will be utilizing required core project components from project options 1.11.1 and 1.11.2. Required core project components include, a) assessing the local availability of and need for expanded video equipment in project counties including expanded access to high speed broadband technology; b) development or adapt current administrative and clinical protocols that will serve as a manual of technology-assisted operations; c)engage in rapid cycle improvement to evaluate the processes and procedures in the expanded telemedicine project and make any necessary modifications; d) identify and train qualified behavioral health providers and peers that will connect to provide expanded telemedicine, to primary care providers, specialty health providers, peers or behavioral health providers. Connections could be provider to provider, provider to patient or peer to peer; e) identify modifiers needed to track encounters performed via expanded telehealth technology; f) develop and implement data collection and reporting standards for expanded electronically delivered services; g) assess impact on patient experience outcomes(e.g. preventable in inpatient readmissions). West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project. This will be accomplished through utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring.

Milestones and Metrics:

Process milestones for this project were selected from those identified for Project options 1.11.1 and 1.11.2. Process milestones were selected to immediately begin assessment of the current systems and begin analysis of the best value, most cost effective decisions regarding equipment, broadband and technology upgrades and procurement. Improvement milestones were selected and adapted for behavioral health from the 1.1 Project Areas: Expand Primary Care Capacity. Improvement milestones were selected based upon information identified both the RHP needs assessment and the Centers own needs assessment process as areas experiencing a severe lack of mental health services. In year 4 telemedicine expansion procurement, testing and installation will have been completed and the focus will shift to the improvement milestones related directly to patient care and access. Year 4 milestone will target a 10% increase in available telemedicine appointment slots. This will increase the current appointments to over 4500 annually to an average patient census of over 850 monthly. The project will also increase access to services through recruitment of additional providers utilizing the expanded telemedicine equipment. Increased access will occur through increasing

available physician appointment times, which will be possible due to the increase/improvement of the telemedicine infrastructure. Once the equipment has been purchased, installed and providers recruited and trained, the year 5 improvement milestone will focus on reductions in waiting times for consumers to obtain an appointment which currently exceed forty-five days in some of the WTC mental health clinics in these counties but averages over twenty days in all of the them. Year 5 will improve waiting times to reduce to seven days the average number of days to third next available appointment for an office visit in each clinic for all telemedicine providers in the project. This measure will improve access to services for all the 850 consumers WTC serves in the region.

Continuous Quality Improvement:

West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution.

Related Category 3 Related Outcome Measure(s):

West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures.

West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This expectation was increased to 40% in DY 5. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

Relationship to other Projects:

This project will be directly related to West Texas Center's RHP 14 Scenic Mountain Medical Center Co-Location/Integration Project number 130725806.2.15.2. The use of telemedicine in an integration project will support and enhance provider communication, collaboration of media events between providers and increase access to both primary care and behavioral health care services.

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

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2

Project Valuation:

West Texas Centers considered the rural nature of behavioral health care delivery in the RHP in the valuation of this project. Access to providers for behavioral health services is so limited; telemedicine has and is providing a mental health "lifeline" to consumers living in these areas. Research continues to support the successful utilization of telemedicine in the diagnosis and treatment of mental illness. Videoconferencing is a proven viable solution to treating consumers who live too far away to regularly have access to professional behavioral health care or were too embarrassed to seek it in conventional ways. [1] Research has identified provider satisfaction with telemedicine, noting in many cases increased openness from patients enabling them to obtain better information than from a face to face encounter.[2] Telemedicine not only brings access to care closer to the patient, it has capacity to significantly reduce the stigma often associated with mental illness. In the counties associated with this project there is currently no local access to a psychiatrist other than through West Texas Center's telemedicine network. Year 4 will see a 10% increase in available telemedicine appointment slots. This will increase the current appointments to over 4500 annually to an average monthly patient census of over 850. Year 5 will improve waiting times to reduce to seven days the average number of days to third next available appointment for an office visit in each clinic for all telemedicine providers in the project. This measure will improve access to services for all the 850 consumers WTC serves in the region.

Due to limited provider capacity, delays in treatment often result in increased emergency department utilization, law enforcement involvement and increased potential for endangerment to the patient and/or the community. This project will provide a cost effective mechanism to improve current access to rural behavioral health care, significantly improve patient appointment wait times, decrease timeframes associated with physician access during crisis situations while continuing to provide effective, evidenced based care to the behavioral health consumer.

[1]Media HealthLeaders. Telemedicine Offers New Alternatives for Behavioral Healthcare Delivery, healthleadersmedia.com September 29, 2012
[2]David Surface. Country Comfort-Mental Health Telemedicine in Rural America *Social Work Today Vol7 No. 1 P.28*

130725806.1.1	1.11	1.11.3 OTHER	WEST TEXAS CENTER RHP 14 TELEMEDICINE EXPANSION
WEST TEXAS CENTERS		130725806	
RELATED CATEGORY 3 OUTCOME MEASURE(S)	130725806.3.1	IT-6.2	PATIENT SATISFACTION
Year 2	Year 3	Year 4	Year 5
Process Milestone 1 [P-X]: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment. Metric 1 [P-X.1]: Inventory of new equipment purchased Data Source: Review of inventory or receipts for purchase of equipment. Baseline: 2012 Inventory of WTC telemedicine equipment. Goal: Purchase all necessary equipment for the project Process Milestone 1 Estimated Incentive Payment: $269,653 Process Milestone 2 [P-X] Procurement of additional Broadband Connection Metric 1 [P-X.1]: Documentation of presence of active broadband connections Data Source: Review of purchase receipt or demonstration of equipment	Process Milestone 3 [P-X] Hire tele-presenters, as needed, for remote site equipment expansion operation. Metric 1 [P-X.1]: Documentation of acquisition of proper staff/training to operate expanded equipment capacity at Provider locations. Data Source: Interviews with staff, review of hiring or payroll records, contracts Baseline: FY 2012 psychiatrist FTE count Goal: Will increase psychiatrist by .25 FTE or ten hours available psychiatrist telemedicine time per week. Process Milestone 3 Estimated Incentive Payment: $280,944.50 Process Milestone 4 [P-X]: Training for providers/peers on use of equipment/software Metric 1 [P-X.1]: Documentation of completions of training on use of equipment/software	Improvement Milestone 1 [I-X] Increase access to behavioral health care capacity Metric 1 [I-X]: Increase number of behavioral health care visits. a. Total number of visits for reporting period. Data Source: Registry, claims or other Performing Provider source Baseline: West Texas Centers FY 2012 claims, encounter and other internal data sources. Goal: Will increase the total number of telemedicine visits by 10%. Telemedicine available appointment slots will increase to a minimum of 4,500 slots annually. Metric will be computed on a twice yearly basis. Improvement Milestone 1 Estimated Incentive Payment: $601,103	Improvement Milestone 2 [I-X] Enhance patient access to behavioral health care services by reducing days to third next available appointment. Demonstrate improvement over prior reporting period. Metric 1 [I-X.1]: Third Next Available Appointment: The length of time in calendar days between the days a patient makes request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be seven calendar days (lower is better), but depending upon the Performing Provides starting point, that may not be possible within the four years). a. Average number of days to third next available appointment for an office visit for each clinic and/or department. Data Source: Practice management or

Baseline: FY 2012 WTC Broadband invoice data Goal: Procure and implement expansion of all Broadband connections required for project. Process Milestone 2 Estimated Incentive Payment: $269,653	Data Source: Training roster Baseline: FY 2012 WTC Provider training records Goal: Complete training on use of equipment/software for all providers utilizing telemedicine in the project. Process Milestone 4 Estimated Incentive Payment: $280,944.50		scheduling systems. Baseline: FY 2012 encounter, claims data; scheduling logs, electronic records Goal: Average number of days to third next available appointment for an office visit in each clinic will be reduced to seven days for the current 850+ WTC consumers WTC serves in the RHP 14 area. Improvement Milestone 2 Estimated Incentive Payment: $580,667
Year 2 Estimated Milestone Bundle Amount: $539,306	Year 3 Estimated Milestone Bundle Amount: $561,889	Year 4 Estimated Milestone Bundle Amount $601,103	Year 5 Estimated Milestone Bundle Amount: $580,667
Total Estimated DSRIP Funding for 4 Years: $2,282,965			

D. Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:
Project Title: Implementation of Comprehensive Heart Failure Patient Management Program:
Unique Project 2 Identifier: 135235306.2.1
Performing Provider: Medical Center Health System TPI 135235306
***DSRIP Project Category* 2.2.2**: Apply evidence-based care management model to patients identified as having high-risk health care needs

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will implement a new methodology of treating heart failure patients. It will include the implementation of a Heart Failure Navigation program focusing on patient education, medication reconciliation, and discharge protocols. MCHS will also be implementing new protocols and procedures for the Chest Pain Center.
- Need for the project: MCHS currently has a very robust inpatient Heart Failure program, but we are continuing to miss the outpatient aspects of Heart Failure treatment management. Our current readmission rate is 25.5% and according to recent data, 30% of patients were discharged with no documented weight and 20% actually gained weight during their stay. We want to streamline the process more to ensure that every aspect of the patient's care is accounted for.
- Target population: The target population is our patients with confirmed Congestive Heart Failure. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to improve the amount of patients with self-management goals. The goal by DY5 is that 100% of patients that enter the Navigation program will have goals set. In terms of patient impact we are already seeing a dramatic increase in patient education prior to discharge. Our Heart Failure Navigator began her duties at the beginning of DY2. In those three months she has been able to educate 252 patients on their disease. We are starting to see a correlation between her educational efforts (e.g. one-on-one with patients, heightened organization wide awareness) and readmissions, but this will require more time to ascertain. However, the initial results are positive. The amount of one-on-one patient education done by our Navigator will remain steady which means educating up to 1000 patients per year in DY3-5.

- Category 3 outcomes: IT-3.2 our goal is to reduce the 30-day potentially preventable congest heart failure readmission rate from by 20% by DY5.

Project Specifics

- Heart Failure Nurse Navigator Program
    - Education of Patients on all elements of CMS HF discharge
    - Medication reconciliation of patient home medications against discharge medications
    - Medication assistance through Social Services, RN Case managers and other agency sources.
    - Establish self-management goals with patients
    - Discharge Follow-up Telephone Call addressing HF discharge instructions, provider follow up and medication reconciliation
    - Education of staff on:
        - HF pathophysiology
        - HF nursing management
        - HF physician management
        - Elements of Discharge Instructions
        - Resources for medication assistance and reconciliation
    - Establish a clinical pathway and order protocols with CPOE increasing provider support and usage
- Utilization of the Chest Pain Clinic for 23 hours observation, triage and diuresis
    - Aquapheresis
        - Medical technology designed to safely remove excess salt and fluids from the body in HF patients with fluid overload to help restore a patient's fluid balance.
        - Beneficial to HF patients who are diuretic resistant as well as those that are not responding to drug therapy.

        - Journal of the American College of Cardiology (JACC) in December 2006 published the RAPID and EUPHORIA studies showing that Aquapheresis improved patient outcomes after therapy both in the hospital and with increased sustainability for three months, when compared to diuretic drug therapy alone.

    - Rapid Diuresis

        - The process utilizing the use of a diuretic to provide forced diuresis which elevates the rate of urination under the supervision of a health provider.

        - Removal of excess fluid with diuretics is one of the mainstays of treating patients especially those with the advance stages of heart failure.

Goals:

- 20% Reduction of readmission rate

5 year expected outcome:

- 20% Reduction of readmission rate

Relationship to Region 14 Goals

MCHS has served as a regional leader in Cardiovascular Disease for many years. We have established a strong reputation for our Chest Pain Center as well. This project will see patients from every corner of RHP 14 and therefore best practices can be shared with that community. RHP 14 has a focus on chronic diseases and CHF treatment innovations meet that need.

Starting Point/Baseline Data (if applicable)

FY 2011 (October 2010 to September 2011) Readmission Rates at MCH = 26%. The current process for HF admission in addressing core measures with the downstream effect on readmission is an Intraprofessional effort with concentration on: discharge instructions, medication reconciliation, and physician follow up. The discharge education which covers the CMS required elements found in the core measure is currently identified as a process that needs to occur at the soonest possible time during the start of admission. Although this component is nurse driven, other professional disciplines will be involved as the need arise. The nurse-physician relationship is important to start the planning process the earliest time during their admission with the need for follow up once the patient is discharged.

Rationale:

- **This project meets CN 1 and 2 as identified in RHP 14's Community Needs Assessment.**

The project intervention Decreasing Congestive Heart Failure 30-Day Readmission Rates is aimed at risk reduction on the mortality of a disease specific population. The project looks into the application of evidence based intervention through a nurse navigation program and engaging HF process from admission to home hitting all elements for safe transition, targeting:

1. Discharge instructions for home
2. Medication reconciliation
3. Family/Community assistance as needed through Utilizations & Outcomes and community resources
4. Follow-up appointment with primary care provider

The interventions will be an Intraprofessional collaborative effort between the nurse navigator, nursing department, primary care providers and other services both intra-organizational and from the community. The basis of our metrics will be a 20% reduction of HF Readmission rates from the FY 2011 baseline of 26%. Preparing the HF patient for discharge is a priority in helping to address and reduce risks for readmission. The project represents a new initiative in that through the Heart Failure Nurse Navigator, risks for readmission are addressed; adherence to follow-up care is ensued with preventable readmission downstream.

Related Category 3 Outcome Measure(s):

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

IT-3.2 Congestive Heart Failure 30 day readmission rate *(Standalone measure)*

This measure makes the most sense given what we are trying to accomplish. Our Cardiac staff, physicians and nursing, all feel that there is a better way to control outpatient heart failure patients and therefore believe that they can positively affect this rate over the course of the waiver.

Relationship to other Projects

This project will work in close conjunction with the Care Transitions project. Both projects are built around the concept that most patients are unable to navigate the extremely complicated outpatient and inpatient settings and therefore need a guiding hand to ensure that unnecessary hospital stays are avoided. This project will have a singular focus due to the high rate of Congestive Heart Failure in this region.

Relationship to Other Performing Providers' Projects in the RHP:

No direct correlation, but many of our patients come from the rural communities. For example, the MCHS cardiac rehab team has been working with rural hospitals (i.e. Pecos County Memorial Hospital) to establish cardiac rehab in their local communities. Patients that are involved with the CHF Nurse Navigator will come from all sections of RHP 14, so coordination with those entities will be essential and crucial.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning

collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2

Project Valuation

The CHF Nurse Navigation Program is a project initiative which would dramatically impact heart failure readmission rates. There were 451 HF patients in FY 2011 with 26% HF same hospital readmission rate. The 117 HF patients readmitted incurred $ 586,000.00 with only the initial day of admission placed into consideration. To further demonstrate the scope of the problem, DSHS reported that between 2005 and 2010 patients in Ector County incurred $54,247,961 in charges that could have been avoided with a proper disease-specific outpatient management program. The scope of this project clearly considers access to care. As part of the nurse navigation program, scheduled HF discharge follow up telephone call is engrained with the process of discharge. A HF Discharge follow up phone call will guarantee follow up on primary care provider appointments, medication questions and clarifications, direction to community resources, discharge components: daily weight, diet, smoking cessation, sodium restrictions, early signs and symptoms of decompensation, and timely follow up appointment.

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the CHF Patient Management Project was deemed to be our 7th most pressing project and therefore was given the 7th highest allocation.

Milestones and Metrics Table

135235306.2.1	***2.2: Expand Chronic Care Management Models***	***2.2.2: Apply evidence-based care management model to patients identified as having high-risk health care needs***	***Implementation of Comprehensive Heart Failure Patient Management Program***
Performing Provider Medical Center Health System		***TPI 135235306***	
Related Category 3 Outcome Measure(s):	***135235306.3.5***	***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 for congestive heart failure Metric 1:[P-3.1]: Documentation of Care management program Data Source: Program materials Milestone 1 Estimated Incentive Payment (maximum amount): $982,994	Milestone 2 [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [P-11.1]: Increase the number of patients enrolled in a self-management program Data Source: EHR, patient registry Milestone 2 Estimated Incentive Payment (maximum amount): $536,197 Milestone 3 [P-10]: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits,	Milestone 4 [I-18]: Improve the percentage of patients with self-management goals Metric 1: [I-18.1]: Patients with self-management goals Goal: 75% of patients entered into Navigation program have self-management goals established. 1000 Patients educated per year. Data Source: Program Registry Milestone 4 Estimated Incentive Payment (maximum amount): $537,755 Milestone 5 [P-X]: Complete utilization of the Chest Pain Center	Milestone 6 [I-18]: Improve the percentage of patients with self-management goals Metric 1: [I-18.1]: Patients with self-management goals Goal: 100% of patients entered into Navigation program have self-management goals established. 1000 Patients educated per year. Data Source: Program Registry Milestone 6 Estimated Incentive Payment (maximum amount): $888,466

	and other interaction types Metric 1[P-10.1]: Increase the number of group visits and/or telephone visits and/or other interaction types. Goal: Hold a minimum of 1 CHF group meeting per month. Data Source: Program Registry, Minutes from meetings Milestone 3 Estimated Incentive Payment (maximum amount): $536,197	for rapid diuresis and Aquapheresis Metric 1 [P-X.1]: Community or population outreach and marketing, staff training, implement Intervention. Goal: Train staff, community, physicians Data Source: Documentation of the competencies, continuing education and certification Milestone 5 Estimated Incentive Payment: $537,756	
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $982,994	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,072,394	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,075,511	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $888,466
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $4,019,365			

Identifying Project and Provider Information:
Project Title: Implementation of Care Transition Program- Transitions Across the Continuum of Care
Unique Category 2 Identifier: 135235306.2.2
Performing Provider: Medical Center Health System TPI 135235306
DSRIP Category: Category 2.9.1 Establish/Expand a Patient Care Navigation Program (CN17)

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This program engages stakeholders (physicians, nurses, other health care providers, patients, family members, and community organizations) in the planning, implementation, and evaluation of a comprehensive program for advancing the patients' ability to manage their disease processes resulting in improved health, prevention of disease exacerbation, and effective management of the treatment plan. By utilizing inpatient care transition nurses and Community Navigators, we can ensure that patients are tracked and managed throughout the continuum of care.
- Need for the project: As the care model evolves, MCHS and local providers need to be connected in more ways than ever before. IT can play a large role, but you still need people to bridge the gap. Ector County is near the bottom of almost every health indicator used, therefore we need to find ways to increase health literacy and walk patients through the complicated medical system. This project will help us bridge that inpatient-outpatient gap.
- Target population: The target population is any patient that is identified using specific criteria that will be set during DY2. Initial conclusions revolve around "frequent flyers" and any patient categorized as "high risk". Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to provide case management and navigation services to a large number of MCHS inpatients and outpatients. Initial baselines aren't available due to this being a new project, but we hope to increase referral to PCP by 15% by the end of DY5. After initial discussions, we feel that this project will impact 10-15% of our inpatient population. This would result in a yearly caseload of 1200 to 1800 patients per year for our Care Transitions Nurses on the inpatient side. The Community Navigators will be receiving patients not only from our inpatient program, but from Community sources as well, so their volumes would be expected to finish in the same general range as the case managers by the end of DY5 as the program expands.

- Category 3 outcomes: IT-3.1 our goal is to reduce the 30-day potentially preventable all-cause readmission rate from by 10% by DY5. *Current rate of 26%.*
- Continuous Quality Improvement: This project has already begun to take shape in terms of establishing CQI markers. We have begun by reexamining our entire process in regards to patient flow and we are challenging traditional roles within the health system. Rapid cycle tests, affinity models, and other tools are being used to ensure that processes are in place to continually improve this project. Stakeholders from across Ector County are already engaged to ensure that collaboration is not only encouraged, but expected.

This program engages stakeholders (physicians, nurses, other health care providers, patients, family members, and community organizations) in the planning, implementation, and evaluation of a comprehensive program for advancing the patients' ability to manage their disease processes resulting in improved health, prevention of disease exacerbation, and effective management of the treatment plan. This plan will be rolled out in two distinct phases in order to ascertain the overall needs of the specified patient population.

- The initial phase for the program will focus on the establishment of hospital-based Care Transition Nursing team. This team will be comprised of 3 Care Transition nurses who will help "at-risk" patients navigate care through their hospital stay and coordinate their post discharge care.

- The second phase of the project will begin in DY 3 and will focus on the establishment of a Community Navigator program in collaboration with the Texas Tech School of Nursing. This segment of the program would be comprised of a team of 3 navigators (1 Advanced Practice Nurse and 2 BSNs) whose primary role would be to work with patients, physicians, and families in order to reduce the readmission rate for the "at-risk" population and help improve their overall health.

- The development of the integrated outreach and patient identification process will allow for the advancement of the program to be used for ensuring the sustainability of the project. Hospitals and health care providers are expected to assist patients to remain out of the hospital for a period of at least 30 days following an exacerbation of a diagnosis (i.e. AMI/HF/COPD). Adult patients and their families will access this program through several different avenues.

The responsibilities of the Care Transition nurse will be:

- **Advocacy & Education** – ensuring the patient has an advocate for needed services and any needed education. The nurse will assist the patient is establishing a successful treatment plan, she/he will procure community services, i.e. home health, DME equipment, meals on wheels, transportation to follow-up appointments, etc.

- **Clinical Care Coordination/Facilitation** – coordinating multiple aspects of care to ensure the patient progresses. The nurse will make appointment with PCP prior to patient leaving the hospital. Nurse will also coordinate care with PCP and other agencies. The nurse will receive follow-up instructions from PCP and alter plan of care as needed. If home health agency is involved in care, the nurse will make weekly contact with agency to assure continuity of care.

- **Continuity/Transition Management** – transitioning of the patient to the appropriate level of care. The nurse will partner with post-acute providers and the Community Navigator to better control the situations that lead to readmissions.

- **Performance & Outcomes Management** – monitoring, and if needed, intervening to achieve desired goals and outcomes for both the patient and the hospital.

- **Psychosocial Management** – assessing and addressing psychosocial needs including individual, familial, and environmental, etc.

- **Research & Practice Development** – identifying practice improvement and using evidence based data to influence needed practice changes. The nurse will monitor the ongoing treatment plan for effectiveness and change plan as needed.

The responsibilities of the Community Navigator will be:

- A transformative/holistic approach that brings together the patient, healthcare providers and community resources in the planning, implementation, and evaluation of a comprehensive program. Appropriate management of healthcare results in improved health, prevention of disease exacerbation, and effective management of the treatment plan.

- Collaboration between the members of the Care Transitions Nursing team project facilitated by Medical Center Health System and the Community-Based Navigator project with Texas Tech University Health Sciences Center School of Nursing – Permian Basin.

- Engaging the client in the decision-making process to identify medical options, personal preferences, and individualized management of health care to ensure effective management of complex treatment plans. The team will utilize eight aspects for the determination of the patient's level of risk including medication, psychological, principal diagnosis, polypharmacy, poor health literacy, patient support, prior hospitalizations in the last 6 months, and palliative care.

- Outpatient care management will utilize a triage approach using phone calls, home visits, and other management options to develop a strong patient-centered orientation for the management of the health care needs.
- The 2 BSN Navigators and APRN working director will work collaboratively to coordinate the care for clients identified as "At Risk" through a wide variety of community resources, such as Agency on Aging, League of United Latin American Citizens (LULAC), Hispanic Chamber, Meals on Wheels, emergency rooms, physicians, health departments, etc.
- Increased coordination of care between health care providers will decrease the number of ED visits, hospital admissions, hospital readmissions, and increase patient satisfaction. Patients lost thru cracks in the system will also be identified.

Patient Flow Diagram

Identification of Complex Patients through Hospital Nursing Care Transition Program, Patient managed by Care Transition RN from admission to discharge

⇩

BSN Navigator receives referral and visits patient

⇩

Determination of Level of Patient Risk

Stable	*Semi-stable*	*Unstable*
Managed by Baccalaureate Navigator	Managed by BSN/APN Navigator	Managed by APN Navigator
⇩	⇩	⇩
Home Plan made with Patient input for resources and engagement methods through using community resources.	Home Plan made with Patient input for resources and engagement methods through using community resources.	Home Plan made with Patient input for resources and engagement methods through using community resources.

Table 1: Levels of Patient Risk

Non Complex	Intermediate Complexity	Complex

• Family members present to assist with management • No changes in medications • Current medications less than 2 per day • No oxygen required for management • No history of depression • Demonstrates adequate health literacy • No indication of needing palliative care services • No hospitalizations within the last 6 months • No readmissions	• Family members available to assist with management • 1-3 new medications added • Current medications 3-5 per day • Oxygen available on as needed basis • Has a history of depression • Demonstrates moderate health literacy • Need to consider palliative care services • Previous hospitalization between 4 to 6 months • 1 to 2 readmissions per year	• No family members available to assist with management • 4 or more new medications added • Current medications greater than 6 per day • Continuous oxygen needed • Currently being treated for depression • Demonstrates inadequate health literacy • Currently qualify for palliative care services • Previous hospitalizations within the immediate past 30 days of discharge

The expected outcomes of this project are:

- Expansion of primary care capacity through the use of appropriate health care providers with "At Risk" clients in the community setting.
- Through the use of the Care Transitions program, "At Risk" clients will be managed using an evidence-based practice foundation to reduce hospital admissions/readmissions, and ER visits.
- Community resources will be engaged to support the management of chronic illnesses with the "At Risk" population.
- Improved patient-centered health care will be provided to positively impact cost/utilization through the use of multiple community resources.

The overall goal for this project is to create a smooth transition of care from inpatient to outpatient settings utilizing the care transitions nurses and then for the community navigators to make sure that the patients understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions. This project when combined with the other aspects of the overall RHP 14 plan should lead to a 10-15% reduction in the overall readmission rate and further integrate medically centered home health care into our patients' daily routine in the Permian Basin region.

Relationship to RHP 14 Goals:

RHP 14 has a strong focus on placing patients in the proper site of care. We all understand that preventing readmissions and admissions cannot be accomplished if you don't give patients the resources and direction they need. This project will help navigate patients through a complicated system and help curb inappropriate ED utilization.

Starting Point/Baseline Data (if applicable)

New program

Rationale:

This project meets community needs: CN1, CN2, and CN5 as identified in in the RHP 14 Community Needs Assessment.

Transitional care encompasses a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care and across care settings. High-quality transitional care is especially important for older adults with multiple chronic conditions and complex therapeutic regimens, as well as for their family caregivers. These patients typically receive care from many providers and move frequently within health care settings. A growing body of evidence suggests that they are particularly vulnerable to breakdowns in care and thus have the greatest need for transitional care services. Poor "handoff" of these older adults and their family caregivers from hospital to home has been linked to adverse events, low satisfaction with care, and high re-hospitalization rates.

Related Category 3 Outcome Measure(s):

IT-3.1 All cause 30 day readmission rate- NQF 1789[28] *(Standalone measure)*

MCHS chose this measure based on the overall scope of the Care Transitions program. Through this endeavor the focus will be on **all** "at-risk" patients, so therefore a look at All-Cause readmission rate is a necessity.

Relationship to other Projects

This project will work in close conjunction with the CHF project and the Faith Based Community Health project. All three projects are built around the concept that most patients are unable to navigate the extremely complicated outpatient and inpatient settings and therefore need a guiding hand to ensure that unnecessary hospital stays are avoided. They all recognize that health literacy is a vital component to ensure that patients play an active role in their care.

Relationship to Other Performing Providers' Projects in the RHP:

No direct correlation, but this will impact patients that return to their rural communities in that they will have a support system that they can utilize through their community navigator.

Plan for Learning Collaborative:

[28] http://www.qualityforum.org/QPS/

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

The foundation for this project is to coordinate the health care for "At Risk" patients in the community setting. Due to the aging population in Odessa and the surrounding counties that are served by MCHS, there is a critical need for the care transition program. Most of the growth is due to the oil boom and the families that have moved into the area are seeking those jobs. Many of these new residents are not insured. Therefore, when these people are admitted to MCHS, we need a plan to get them discharged to the next level of care in a safe and continuous manner. The Care Transitions program is proposed as a means for serving a population at risk for chronic disease exacerbation; providing cost avoidance by decreasing the number of hospital admissions/ readmissions, and ED visits; and addressing community needs identified in the community assessment while allowing for increased patient communication and family/ancillary involvement in implementing the plan of care. Based on DSHS data, cost avoidance of readmissions and emergency room visits would have saved the system $216,138,877.00 between 2005 and 2010 had this project been in place. An example of cost avoidance for COPD patients, 1894 cases could have been handled in an outpatient setting potentially resulting in a cost savings of $39,128,728.

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Care Transitions project was deemed to be our 5th most pressing project and therefore was given the 5th highest allocation.

Milestones and Metrics Table

All P-X milestones are from Additional Process Milestones on Page 8

135235306.2.2	***2.9***	***2.9.1***	***IMPLEMENTATION OF CARE TRANSITION PROGRAM- TRANSITIONS ACROSS THE CONTINUUM OF CARE***
PERFORMING PROVIDER MEDICAL CENTER HEALTH SYSTEM		***TPI 135235306***	
RELATED CATEGORY 3 OUTCOME MEASURE(S):	***135235306.3.6***	***IT 3.1***	***ALL CAUSE 30 DAY READMISSION RATE- NQF 1789 (STANDALONE MEASURE)***
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-X]: Hire 3 Care Transitions nurses to manage patients on the inpatient side to identify needs and patients. Metric 1: [P-X.1]: Hire 3 Care Transitions Nurses. Goal: Hire Transition nurses by end of DY2 Data Source: Job description Milestone 1 Estimated Incentive Payment (maximum amount): $534,283 Milestone 2 [P-X]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Community Patient Navigator program. Metric 1 [P-1.1]:Provide report	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 1 [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators Baseline/Goal: Initial Goal is 3 Community Navigators Data Source: Program Materials Milestone 3 Estimated Incentive Payment (maximum amount): $582,874 Milestone 4 [I-X]: Establish Baseline for patients enrolled in Care Transitions Program Metric 1 [I-X.1]: Number of patients referred to Care	Milestone 5 [P-3]: Provide care management and navigation services to targeted patients. Metric 1: [P-3.1]: Increase in the number or percent of targeted patients enrolled in the Community Navigator program Goal: 10% increase over DY3 Baseline (Represents 120 Patients) Data Source: Enrollment Reports Milestone 5 Estimated Incentive Payment (maximum amount):	Milestone 6 [P-3]: Provide care management and navigation services to targeted patients. Metric 1: [P-9.1]: Increase in the number or percent of targeted patients enrolled in the Community Navigator program Goal: 15% increase over DY3 Baseline (Represents 150 patients) Data Source: Enrollment Reports Milestone 6 Estimated Incentive Payment (maximum amount): $482,905 Milestone 7 [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care,

identifying suggested list Baseline/Goal: Complete assessment by end of DY2 Data Source: Program Documentation Milestone 2 Estimated Incentive Payment (maximum amount): $534,284	Transitions program upon admission or during inpatient stay Goal- 10% of admissions (100 patients per month average) Data Source: EHR Milestone 4 Estimated Incentive Payment (Maximum amount): $582,875	$1,169,138	and/or hospital services. Metric 1: [I- 6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: 85% of navigated patients directed to Medical Home Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program Milestone 7 Estimated Incentive Payment (maximum amount): $482,905
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $1,068,567	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,165,749	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,169,138	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $965,810
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 4,369,264			

Identifying Project and Provider Information:
Project Title: Implementation Severe Sepsis Program-Early Detection and Education
Unique Category 2 Identifier: 135235306.2.3
Performing Provider: Medical Center Health System TPI 135235306
DSRIP Category: Category 2.8.11 Sepsis

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will implement more rigorous protocols and procedures in the detection and treatment of Sepsis. An overhaul of local and regional education will be implemented as well.
- Need for the project: We currently have a Sepsis program, but it is very limited in its resources and reach. By expanding the program to include a full-time Sepsis Coordinator, we will be able to educate more internal employees and improve regional outreach to ensure that patients are identified.
- Target population: The target population is all hospital inpatients. We have to ensure that all patients are properly vetted and screened for sepsis and that identified patients are treated accordingly. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to provide training to internal and external employees on a consistent basis; therefore additional staff will be required to meet that goal. This will result in better detection and treatment for all of RHP 14. There has been an average reduction of 66% Severe Sepsis (SS) and Septic Shock (SSH) patients in the last three consecutive quarters. It is not that the patients are not as sick, but that the nurses and physicians are better recognizing the risk of SS and SSH development in our already septic patients. The mortality rate is well below the national benchmark of 29%, MCHS' mortality has sustained an average mortality rate of 20% in the last three consecutive quarters. With the supplementation of the Waiver monies, the Clinical Sepsis Coordinator will be able to focus full-time on educational opportunities with both internal employees, as well as facilities within the region. This should help in the detection of sepsis and hopefully recognition into severe sepsis/septic shock phases; the sooner the recognition, the sooner the treatment and better outcomes. There will be another educational focus of helping the community to understand the impact of sepsis. This begins with the establishment of what the community knows and where to educate from there. The goal is to enable the public to understand that sepsis is an emergency, much like MIs and Strokes. In addition, a support group will be established to help the survivors and victims of sepsis. This will begin with an in-house consultation of the Clinical Sepsis Coordinator and continue after

discharge to help deal with the impacts of the survivors. If we can save just one more patient, that is enough to touch many people and I believe we are well on our way to reducing our mortality rate even more. In 2012, there were 245 severe sepsis/septic shock patients. 54 of the patients died, which is a 22% overall mortality rate for 2012. The goal is to have a 15% reduction in mortality by Year 5 of the Waiver. This would mean that we would hold a consistent overall mortality rate of 19%.

- Category 3 outcomes: IT-4.8 our goal is to reduce Sepsis Mortality by 15% by DY5.

Numerous reports over the past decade have established the time-sensitive window of opportunity for effective resuscitative and infection control interventions in patients with severe sepsis. Specifically, delays in timely diagnosis and prompt treatment results in increased mortality (by as much as 7.6% for each hour of delay for antibiotics alone).

The present gains in reducing patient mortality are limited by the variable time of patients' presentation for medical care. The present guidelines promoted by the Surviving Sepsis Campaign and the endorsing professional organizations focus on prompt diagnosis and intervention by clinicians to maximize the benefit to patients through time-sensitive care.

Close examination of public's familiarity with the manifestations of myocardial infarction and need for prompt EMS activation demonstrates disparities in population's health literacy. Specifically, minorities and the less educated are less familiar with heart attack manifestations and need for prompt EMS activation. These data are in line with a body of research demonstrating that lower health literacy is associated with higher mortality.

Thus, the population most adversely affected by severe sepsis may be also less likely to benefit from the successful implementation of inpatient resuscitation programs, as these patients may present later for medical care. Of note, although patients without health insurance or Medicaid utilize ED services more often than those with private insurance, in part due to limited access to primary care, such patients may also delay coming to ED if they think this may lead to hospitalization, given the resultant adverse financial and work-related consequences.

In 2008, Medical Center Hospital implemented a Severe Sepsis Management Program. The Program has involved training clinicians, restructuring care processes, and acquiring point-of-care equipment. The hospital's Medical Executive Committee approved the core elements of time-based bundled diagnosis, resuscitation and proper antimicrobial therapy as mandatory core measures for medical staff, on par with those mandated by CMS for other conditions. In addition, as part of the Program, the hospital hired a nurse to act part-time as a Severe Sepsis Clinical Coordinator to assist in the oversight, education and running of the Program. Finally, a multidisciplinary Severe Sepsis Management Group was created to assure overall quality of performance, education, and individualized feedback to clinicians.

Following implementation of the aforementioned Program, the adherence to the elements of severe sepsis diagnosis, resuscitation bundle, and timely initiation of appropriate antimicrobial therapy showed progressive improvement. The present performance on these bundled measures at the local Emergency Department surpasses that of top-performing hospitals in the Surviving Sepsis Campaign (SSC) Registry. MCH had a decline in hospital

mortality of patients with severe sepsis by 37%, which is lower than the benchmark for high-performing facilities in the SSC Registry.
Although there has been improvement in the diagnosis and resuscitation of patients developing severe sepsis on general medical wards, the gains were more limited, and patients' outcomes remain significantly worse than those whose severe sepsis are managed first in the ED and then admitted to the ICU.

A revision was made in the hospital's Rapid Response Team (RRT) procedures at the end of 2011, introducing nurse-driven, medical staff-approved diagnosis and resuscitation protocols in patients with suspected severe sepsis. However, although there was an improvement in adherence to the resuscitation bundle of sepsis, the gains were again limited, with markedly lower performance compared to ED, and with higher mortality of ward patients with severe sepsis.

Relationship to RHP Goals

This project meets regional goals in that MCHS serves as the regional leader for Sepsis treatment. Our plan has regional training built into it and therefore we can help streamline transfers and improve diagnosis times throughout RHP 14.

Goals/5 Year Expected Outcomes:

1. 15% reduction in Sepsis Mortality
2. Increased Public Awareness around Sepsis (Symptoms, Effects, Prevention)
3. Increased Education for physicians and nursing on early detection and proper treatment guidelines

Challenges/Issues:

1. Complicated topic. Will public understand message?
2. Finding qualified staff for Surveillance Nurse positions

Starting Point/Baseline Data (if applicable)

Collect the data of the sepsis patients who developed severe sepsis/septic shock on the ward level. Establish a baseline for the public's current awareness and knowledge of sepsis. Because the city of Odessa is among the largest metropolitan areas in RHP 14, the baseline data obtained from local residents will be assumed to represent the upper level of population's awareness about severe sepsis, as compared to the remainder population residing in more rural areas.

Rationale:

- **This project meets CN2 (High costs associated with preventable hospitalization admissions and readmissions) as identified in the RHP 14 Community Needs Assessment.**

The first phase of our program will be to establish in detail the time lapse from the 1st evidence of infection-related organ dysfunction/failure to activation of RRT (or time to initiation of RRT-independent resuscitative efforts), and meeting time-based resuscitative and infection

control measures. Patients will be identified through the ongoing severe sepsis management program database and RRT records. We will further analyze the association the timeliness of diagnosis and resuscitative intervention and patients' outcomes (hospital mortality).

In addition, the Severe Sepsis Management Group and hospital's Information Technology staff will convene to review present capabilities of the local health information systems to track and identify electronically posted indicators suggestive of severe sepsis.

Among patients hospitalized with severe sepsis at Medical Center Hospital during the period between 2006 through 2010, 41% were minority. Among non-Medicare patients, 56% had either Medicaid or no health insurance. The latter figure was 43% among Caucasians, 72% for Hispanics, and 76% for Blacks. These figures underscore the disproportionate representation of groups more likely to develop severe sepsis and incur adverse outcomes as a result.

Related Category 3 Outcome Measure(s):

This project is related to IT-4.8 Sepsis Mortality. According to the Institute for Healthcare Improvement (IHI), sepsis is the leading cause of death in the ICU and the national mortality rate is 30-50%. Even after a patient has survived this illness, the patient remains at risk of dying within the first month of survival (30%) and within 6 months (50%) (IHI). It is estimated that severe sepsis and septic shock treatments tally up to $17 billion annually in healthcare costs (Warren & Ruppert, 2012).

The disparities in the burden of severe sepsis with minorities, the under privileged, and those without health insurance have an increased incidence of severe sepsis and increased sepsis-associated mortality. In addition, these population groups are less likely to be familiar with "sepsis." Patients residing in rural areas are more likely to share one or more of these demographic traits.

Relationship to other Projects

This project will relate to the Implementation of a Mobility Team Project because literature has shown that the incidence of pressure ulcers is correlated to the development of sepsis. By supporting the implementation of the mobility team to prevent pressure ulcers, the risk for development of sepsis in these patients is decreased. The sepsis project will also help support the Ector County Health Department and the diabetic screening and care. If not controlled, diabetes can contribute to low rates of healing wounds and development of new wounds. Wounds are a leading source of infection in sepsis. The project will also reinforce the preventive measures of public health screening. And lastly, it will enable the LEAN training to reinforce cost effective care by providing early sepsis treatment and hopefully preventing lengthy and costly ICU stays.

Relationship to Other Performing Providers' Projects in the RHP:

Odessa Regional Medical Center is also pursuing a project based around improving Sepsis Mortality. There are plans to share best practices and communicate on a regular basis.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a

yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

For this project, our two focuses are community outreach and awareness, and improving early diagnosis and resuscitation of ward patients. The populations served in Ector County Hospital District (ECHD) include those from outlying facilities within the region. Often times, they are underprivileged and of non-English speaking language. Therefore, to provide community outreach and awareness, we will need to consider the best location to teach awareness, as well as provide a form of interpretation, for both written materials and in-person.

For the ward identification of patients, hiring nurses and training them to do comprehensive concurrent monitoring of the highest risk patients will help to identify the patients before the risk of severe sepsis sets in. The time and financial resources to train these nurses would occur during DY 3.

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Sepsis project was deemed to be our least pressing project and therefore was given the smallest highest allocation.

Milestones and Metrics Table

135235306.2.3	*2.8.11*	*2.8.11*	*SEVERE SEPSIS RESUSCITATION AND MANAGEMENT: IMPROVING EARLY DIAGNOSIS AND RESUSCITATION AMONG WARD PATIENTS*
MEDICAL CENTER HEALTH SYSTEM		*135235306*	
RELATED CATEGORY 3 OUTCOME MEASURE(S):	*135235306.3.7*	*IT 4.8*	*SEPSIS MORTALITY*
Year 2 (10/1/2012 – 9/30/2013)	**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]: Hire Full-time Clinical Sepsis Coordinator Metric 1:[P-X.1] Documentation of hire Data Source: Human Resources Milestone 1 Estimated Incentive Payment (maximum amount): $216,047 Milestone 2: [P-1]: Target specific workflows, processes and/or clinical areas to improve Metric 1:[P-1.1]: Performing Provider review and prioritization of areas or processes to improve upon Data Source: Written Report Milestone 2 Estimated Incentive Payment (maximum amount): $216,047	Milestone 3: [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events. # of events Goal: 8 Events- 4 Internal Programs, 4 External/Community Programs Data Source: Program Materials, Schedule Milestone 3 Estimated Incentive Payment (maximum amount): $235,696 Milestone 4 [P-8]: Train providers/staff in process improvement. Hire 1-2 new Sepsis Surveillance Nurses. Metric 1 [P-8.1]: Number of providers/staff trained	Milestone 5[P-X]: Collaborate with IT to develop an electronic alert for severe sepsis. Metric 1: [P-X.1]: Create prototype alert Data Source: Documentation of alert indicators Milestone 5 Estimated Incentive Payment (maximum amount): $236,381 Milestone 6 [P-11]: Number of trainings conducted by designated trainee/process improvement champions Metric 1 [P-11.1]: Trained by the trainee/champion trainings a. Number of trainings conducted by designated process improvement trainees/champions	Milestone 7: [P-12] Report findings with AACN, SCCM & SSC to foster shared learning and benchmarking across the state and national levels Metric 1 [P-12]: Final Report/report summary Data Source: All data sources used for the process improvement events. Milestone 7 Estimated Incentive Payment (maximum amount): $195,271 Milestone 8: [I-16]: Improved Clinical Indicator Metric 1 [I-16.2]: Improved Clinical Indicator: Appropriate Care Measure (Core Measure) Goal: 75% (Currently at 42.7%)

	Metric 2 [P-8.2]: Number of trainings held Data Source: Curriculum or training schedules, Hiring Documentation Milestone 4 Estimated Incentive Payment (maximum amount): $235,696	b. Number of providers/staff trained by designated process improvement trainees/champions Goal: 4 Surveillance Nurses conduct 48 trainings, 300 People trained Data Source: Training program curriculum, educational materials, attendance lists Milestone 6 Estimated Incentive Payment (maximum amount): $236,381	Data Source: Core Measure Data Milestone 8 Estimated Incentive Payment: $195,272
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $432,094	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $471,392	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $472,762	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $390,543
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $1,766,791			

Identifying Project and Provider Information:
Project Title: The implementation of a Mobility Team preventive strategy to reduce the incidence of hospital acquired pressure ulcers
Unique Category 2 Identifier: 135235306.2.4
Project Option: 2.8.5
Performing Provider: Medical Center Health System TPI: 135235306

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This quality improvement project focuses on the implementation of an innovative prevention strategy to reduce the incidence of hospital acquired pressure ulcers. The implementation of a focused "mobility team" model can reduce the incidence of hospital acquired pressure ulcers as the team assistants focus on: improving mobility, activity, assisting patients out of bed for all meals, educating & engaging patients and families, increasing awareness from all healthcare providers, and partnering with physical therapy and dieticians to meet patient activity and dietary needs.
- Need for the project: Despite 7 years of concerted efforts to reduce these rates, sustainable and favorable outcomes have not been readily achieved at the acute care facility. The challenges facing this project are lack of funding, staffing, and available healthcare resources.
- Target population: The target population includes all hospitalized patients at risk for the development of pressure ulcers based on the Braden Scale Score and individualized risk factors. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The 5 year expected outcome is to reduce the incidence of hospital acquired pressure ulcers by at least 25% with the implementation of mobility teams throughout the facility. Implementation of 7 more mobility teams to help reduce occurrence and increased education will also be facets of this project. The patient population impact is significant for the Mobility Team/Pressure Ulcer reduction Waiver project. With every pressure ulcer that is avoided as a result of the Mobility Team, patients gain the ability to return home independently, length of stay can be reduced, along with a reduction in morbidity and mortality. According to CMS, each extensive pressure ulcer avoided accounts for $43,180 in savings. In addition the cost avoidance can be measured in terms of value-based purchasing initiatives due to the potential to improve patient satisfaction.

- Category 3 outcomes: IT-4.7 The 5 year expected outcome is to reduce the incidence of hospital acquired pressure ulcers by at least 25% with the implementation of mobility teams throughout the facility.

This quality improvement project focuses on the implementation of an innovative prevention strategy to reduce the incidence of hospital acquired pressure ulcers. Despite 7 years of concerted efforts to reduce these rates, sustainable and favorable outcomes have not been readily achieved at the acute care facility. The challenges facing this project are lack of funding, staffing, and available healthcare resources.

The implementation of a focused "mobility team" model can reduce the incidence of hospital acquired pressure ulcers as the team assistants focus on: improving mobility, activity, assisting patients out of bed for all meals, educating & engaging patients and families, increasing awareness from all healthcare providers, and partnering with physical therapy and dieticians to meet patient activity and dietary needs. The mobility team concept has been trialed on 1 acute care unit with positive and favorable patient outcomes since March 2012. The 5 year expected outcome is to reduce the incidence of hospital acquired pressure ulcers by at least 25% with the implementation of mobility teams throughout the facility.

Project Specifics:

- Each team is comprised of 3-6 FTE mobility assistants (minimum job requirement is that the mobility assistant be in nursing school) 3 FTEs are assigned to each acute care unit; 6 FTEs are assigned to each critical care unit
- Each team is assigned to one patient care unit and is employed in a "flex pool" on a part time basis
- The mobility assistants are oriented and educated extensively on pressure ulcer prevention, skin care, repositioning, and safety with mobility
- The main focus of each team is to educate and engage patients and families on pressure ulcer prevention through the use of equipment, patient education materials (videos and handouts) and other prevention resources
- In addition, volunteer opportunities exist within the Mobility Team model because of the collaborative relationship with the local nursing schools

Relationship to RHP 14 Goals

RHP 14 has a deemed PPA, PPR, and PPC as priorities in the waiver. Pressure Ulcers acquired at MCHS affect the entire region considering how many patients come from outside Ector County. By implementing this project we will be able to send patients back to their respective communities with fewer pressure ulcers and their long-term effects.

5 Year Goals:

1. 25% reduction in Hospital Acquired Pressure Ulcers
2. 10-15% increase in patient satisfaction scores

3. More coordinated relationship with the Texas Tech School of Nursing

Challenges/Issues:

1. Staffing
2. Very aggressive goals, population increases will only increase volume.

Starting Point/Baseline Data (if applicable)

Quarterly facility acquired pressure ulcer rates: baseline total average is: 9.7

CY2010: Q1: 15%	Q2:13%	Q3:5%	Q4: 12%
CY2011 Q1: 11%	Q2:8%	Q3: 9%	Q4: 12%
CY2012 Q1: 6%	Q2: 6%		

Rationale:

- **This project meets CN2 as identified in the RHP 14 Community Needs Assessment.**

Pressure ulcers are costly, physically debilitating, and potentially preventable events occurring in acute care settings. The risk of missed reimbursement far outweighs the implementation costs of an innovative resource-driven Mobility Team to reduce risk in hospitalized patients. With an increase in national attention to achieve optimal patient outcomes while reducing operating costs, it is essential for leaders and clinicians to embrace innovative approaches to deliver patient care. Traditional prevention strategies may not truly suffice existing patient needs. Therefore, a proactive approach to meeting resource gaps is necessary. The implementation of a Mobility Team can help address practical issues facing the nursing profession. The average cost to treat a pressure ulcer is $43,000 (Centers for Medicare & Medicaid Services, 2008). 17,000 lawsuits and 60,000 deaths annually are associated with ulcers, with over 2.5 million patients affected each year (AHRQ, 2011; Reddy, Gill & Rochon, 2006). Prevention is fundamental requiring new strategies to educate & empower patients. As a cost effective strategy, the Mobility Team was designed to supplement the multidisciplinary team with a specific goal of reducing patients' risk for pressure ulcer development through: education, patient/family engagement, and improved mobility. The utilization of all available resources is vital to ensure economic salience and to promote quality of care. The implementation of a cost-effective team as a prevention strategy can potentially yield favorable outcomes for patients. The Mobility Team model was piloted on two medical units with preliminary favorable patient outcomes and feedback. The 1115 Medicaid Waiver plan now is to expand the mobility team model throughout the entire facility to reduce pressure ulcer incidence at the system level. In addition, there is a pressing need to employ a full time certified Wound and Ostomy Nurse within the system, which currently does not exist, to further support staff in the reduction of ulcers through education, rounding, and direct patient care as needed.

Related Category 3 Outcome Measure(s):

- IT 4.7
- In terms of cost avoidance, the reduction of hospital acquired pressure ulcer rates can not only benefit the RHP, but will ultimately improve patient care, quality of life and has the potential to reduce morbidity and mortality in the region.
- The proposed project will implement evidence-based, reputable supported guidelines from nationally recognized organizations such as the Institute for healthcare Improvement (IHI), National Pressure Ulcer Advisory Panel (NPUAP), Agency for Healthcare Research and Quality (AHRQ), and Wound Ostomy and Continence Society (WOCN)

Relationship to other Projects

This project also supplements the goals of the Sepsis Project in that patients with pressure ulcers are at a high risk for developing Sepsis as a subsequent complication. In addition, Septic patients with additional co-morbidities do also tend to develop pressure ulcers. Therefore, both conditions are interrelated.

Relationship to Other Performing Providers' Projects in the RHP:
None

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

This project was approached from a cost avoidance perspective. According to CMS, the average cost to treat a pressure ulcer is over $43,000. Therefore, in terms of cost avoidance and due to historical pressure ulcer data, it was deemed cost effective to implement mobility teams throughout the facility in an effort to reduce the burden that hospital acquired ulcers place on patients, families, caregivers, other healthcare providers and facilities, and ultimately on the community.

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?

2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Mobility Teams/Pressure Ulcers project was deemed to be our 8th most pressing project and therefore was given the 8th highest allocation.

Milestones and Metrics Table

135235306.2.4	***2.8***	***2.8.5*** ***REDUCTION IN POTENTIALLY PREVENTABLE COMPLICATIONS (PPC)***	***THE IMPLEMENTATION OF A MOBILITY TEAM PREVENTIVE STRATEGY TO REDUCE THE INCIDENCE OF HOSPITAL ACQUIRED PRESSURE ULCERS***
PERFORMING PROVIDER ***MEDICAL CENTER HEALTH SYSTEM***		***TPI*** ***135235306***	
RELATED CATEGORY 3 OUTCOME MEASURE(s):	***135235306.3.8***	***IT 4.7***	***HOSPITAL-ACQUIRED DEEP PRESSURE ULCERS***
Year 2 **(10/1/2012 – 9/30/2013)**	**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]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of providers/staff trained. Data Source: Program Materials/Logs Metric 2 [P-8.2]: Number of trainings held Goal: • 1 Full-Time Wound Ostomy Nurse trained and hired • 2 Mobility Teams (6FTEs) installed and trained • 4 Internal Training Sessions, 4 Community Training Sessions Data Source: Documentation of completion. Program Materials	Milestone 2 [P-8]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of providers/staff trained. Data Source: Program Materials/Logs Metric 2 [P-8.2]: Number of trainings held Goal: • Baseline/Goal: 2 Mobility Teams (6FTEs) installed and trained • 4 Internal Training Sessions, 4 Community Training Sessions Data Source: Documentation of completion. Program Materials Milestone 2 Estimated Incentive	Milestone 3 [P-8]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of providers/staff trained. Data Source: Program Materials/Logs Metric 2 [P-8.2]: Number of trainings held Goal: • Baseline/Goal: 2 Mobility Teams (6FTEs) installed and trained • 4 Internal Training Sessions, 4 Community Training Sessions Data Source: Documentation of completion. Program Materials Milestone 3 Estimated Incentive	Milestone 4 [P-8]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of providers/staff trained. Data Source: Program Materials/Logs Metric 2 [P-8.2]: Number of trainings held Goal: • Baseline/Goal: Last Mobility Teams (3 FTES) installed and trained • 4 Internal Training Sessions, 4 Community Training Sessions Data Source: Documentation of completion. Program Materials

Milestone 1 Estimated Incentive Payment (maximum amount): $881,863	Payment (maximum amount): $962,065	Payment (maximum amount): $964,862	Milestone 4 Estimated Incentive Payment (maximum amount): $265,688 Milestone 5 [P-12]: Report findings and learnings Metric 1 [P-12.1]: Final report/report summary Data Source: All data sources used for the process improvement events Milestone 5 Estimated Incentive Payment (maximum amount): $265,686 Milestone 6 [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal Data Source: EHR Goal: 25% reduction in Hospital Acquired Pressure Ulcers over original DY2 baseline Milestone 6 Estimated Incentive

			Payment (maximum amount): $265,686
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $881,863	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $962,065	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $964,862	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $797,060
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $3,605,850			

Identifying Project and Provider Information:
Project Title: Diabetes Screening and Navigation (Hospital/Health Department Collaboration)
Unique Category 2 Identifier: 135235306.2.5
Project Category: 2.7.6
Performing Provider: Medical Center Health System TPI: 135235306

Project Description:

- Collaboration: This project is being funded through collaboration. The Ector County Health Department is a great community partner for Medical Center Health System and was very excited about the prospects of the waiver project. Representatives from the Health Department and MCHS began to work together on crafting a new Diabetes Outreach program. The original intent was to utilize the MCHS Diabetes Center as a resource for the Health Department's project, but as the deadlines grew closer, the county was unsure of the funding structure and the details. They wanted to ensure that all dollars allocated to them remained in Ector County, so they agreed to allocate the dollars to Medical Center Health System. Moving forward, the Health Department will be an active participant in the planning and execution of this new Diabetes Project.
- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will revolve around two Diabetes Outreach Coordinators who will be responsible for:
    - Coordinating and performing screening events at businesses, churches, and community events.
    - Referrals of patients ages 18-75 made to primary care providers for the purpose of establishing a diagnosis of diabetes, and a patients' medical home
    - Health Promotion and education
- Need for the project:
    - Ector County ranked in the 4th quartile (lowest) in the 2012 County Health Rankings in terms of diabetic screening.
    - Ector County is 54% Hispanic, but only 41% of patients seen at the Diabetes Center were Hispanic. Given that Mexican American adults are 1.8 times more likely than non-Hispanic white adults to have been diagnosed with diabetes by a physician according to the CDC this becomes an issue.
    - Adult Potentially Preventable Hospitalizations for Diabetes Long-term Complications accounted for $20,614,043 in unnecessary charges form 2006-2010 according to DSHS.
    - There are two congressional districts that cover Region14. According to the American Diabetes Association, the total cost of diabetes for people in

Congressional District 11 in 2006 is estimated at $424,200,000. This estimate includes excess medical costs of $289,700,000 attributed to diabetes, and lost productivity valued at $134,500,000. The total cost of diabetes for people in Congressional District 23 in 2006 is estimated at $480,900,000. This estimate includes excess medical costs of $324,000,000 attributed to diabetes, and lost productivity valued at $156,900,000.

  - Same study showed that only 41.2% of those patients were Hispanic, which when coupled with the CDC data and population data tells us that we are doing a poor job of identifying Hispanics with Diabetes

- Target population: The target population is any Ector County resident that hasn't been properly screened for diabetes. We will be focusing on underserved areas that have high uninsured and Medicaid populations. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: The project seeks to identify, refer, and track 50 diabetic patients in DY3, 100 in DY4, and 150 in DY5. In addition to referrals to intensive diabetes education, the outreach coordinators will also hold community education sessions on a regular basis. The expectation will be a minimum of 4 per month. While we only expect to identify a certain number of patients, we expect to perform 2-4 screening events per week, which will result in thousands of Odessans being screened, while increasing overall awareness about diabetes.
- Category 3 outcomes: IT-2.9 our goal is to reduce the uncontrolled diabetes admission by 15% by DY5.

It is a strategic priority of Ector County Health Department and Medical Center Health System to provide patients diabetes screening/referrals throughout our community. During the waiver planning process the Ector County Health Department and Medical Center Health System saw a unique opportunity to take Medical Center's resources and the Health Department's community outreach ability and form them into a project that would more aggressively screen for diabetes. This project will revolve around two Diabetes Outreach Coordinators who will be responsible for:

- Coordinating and performing screening events at businesses, churches, and community events.
- Referrals of patients ages 18-75 made to primary care providers for the purpose of establishing a diagnosis of diabetes, and a patients' medical home
- Health Promotion and education

The screening idea is very simple at its core. It is our belief that many of the patients in Ector County are intimidated by the complexity of the Health System and therefore don't seek care when it is desperately needed. The coordinators would take mobile HbA1c testing to the patients. MCHS has established a relationship with Wellness Works, who will help the

coordinators work with the business community and then through the Faith Based Community Care Project we will be able to establish screenings in the congregations.

The Health Department has a long history of community education, but has been lacking in the needed resources to fulfill their mission. MCHS has been looking for ways to reach the patient on their terms, instead of waiting for the patient to present at our ED. Both organizations feel that this project can help both achieve their goals. MCHS has a vast number of resources available for patients with Diabetes, but often time's commercial and government payers are unwilling to pay for Diabetes education. This means that the patients with the greatest need are often unable to get the support they need to manage their disease. Through the funds provided by the waiver, MCHS's Diabetes Center (ADA Accredited) will have a fund established that allows them to provide 10 hours of ADA (American Diabetes Association) accredited diabetes education to 100 patients a year at no cost to the patient. This equates to about $30,000 per year in classes. The coordinators will also be responsible for presenting diabetes education in varying community venues.

Relationship to RHP 14 Goals

Diabetes rates in RHP 14 are among some of the highest in the state and that is without reaching 30-40% of our population according to different experts in our region. Through this screening process we hope to garner a better understanding of the depth of the problem in our area. We hope that this model becomes something that we can replicate in other counties as time goes on.

Challenges:

- Ensuring patient follow through
- Overall scope of problem- 30,000-40,000 people in Ector County who have never been screened according to some estimates.
- Insurers willingness to cover costs of classes

Goals:

- The goal of this project is to decrease the uncontrolled diabetes admission rate by 15% by the end of DY 5.
- Navigate a total of 300 newly diagnosed patients to a medical home that fits their needs.
- 75% of referred patients go through Diabetes Center courses

Starting Point/Baseline Data (if applicable)

Baseline Data from the Diabetes Center:
498 Patients went through the education courses: Extremely low considering population

- 18 With Pre-Diabetes
- 12 Type 2 plus Pregnancy
- 2 Pre-Diabetes Ages 0-18

- 16 Pre-Diabetes 19 and higher
- 208 Hispanic patients, 23 African Americans

Rationale:

This project addresses community needs CN1 and CN2 from the RHP 14 Community Needs Assessment.

- Ector County ranked in the 4th quartile (lowest) in the 2012 County Health Rankings in terms of diabetic screening.
- Ector County is 54% Hispanic, but only 41% of patients seen at the Diabetes Center were Hispanic. Given that Mexican American adults are 1.8 times more likely than non-Hispanic white adults to have been diagnosed with diabetes by a physician according to the CDC this becomes an issue.
- Adult Potentially Preventable Hospitalizations for Diabetes Long-term Complications accounted for $20,614,043 in unnecessary charges form 2006-2010 according to DSHS.
    - Same study showed that only 41.2% of those patients were Hispanic, which when coupled with the CDC data and population data tells us that we are doing a poor job of identifying Hispanics with Diabetes

Related Category 3 Outcome Measure(s):

135235306.3.10- **IT-2.9 Uncontrolled Diabetes Admissions Rate PQI 14245**

This measure accurately reflects our efforts in the community. If we are identifying patients and navigating them to the proper site of care, this rate should be affected.

Relationship to other Projects

This project merges well with three projects for MCHS:

1. Faith Based Community Care
2. Eliminate Disparities in Health Care Access for the uninsured and underserved population of West Odessa- West Odessa Family Health Clinic
3. Care Transitions

Relationship to Other Performing Providers' Projects in the RHP:

No direct correlation, long-term we might try to expand this concept regionally.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

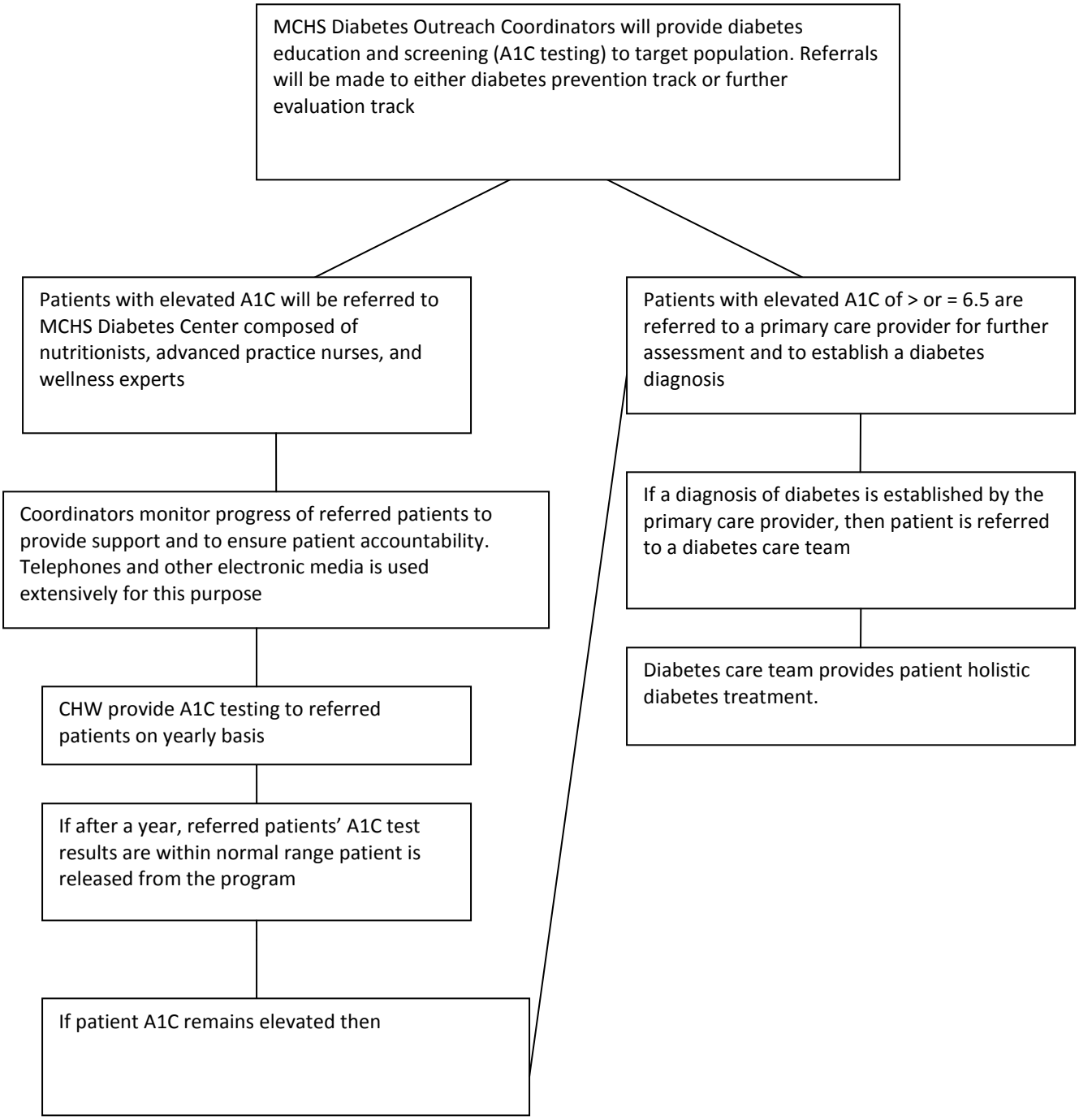
MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Diabetes was deemed to be our 4th most pressing project and therefore was given the 4th highest allocation.

Diabetes is an epidemic in West Texas. We have some of the highest rates in the state and then couple that with our uninsured rate and the outlook is even graver. This project is necessary to identify at risk patients before they become uncontrollable. Numerous studies have shown that diabetes when identified early can be controlled outside of the hospital setting. With this project we expect to identify numerous diabetics, as well as pre-diabetics, and will then send them to their proper site of care.

Diagram 1: Referral Flow Sheet



Milestones and Metrics Table

All Milestones and Metrics were chosen from 2.7 menus. We wanted to focus on diabetes, so 2.7.6 was chosen.

135235306.2.5	***2.7.6***	***2.7 - Implement Evidence-based Disease Prevention Programs***	***Diabetes Screening and Navigation (Hospital/Health Department Collaboration)***
Performing Provider Medical Center Health System		***TPI 135235306***	
Related Category 3 Outcome measure(s):	***135235306.3.10***	***IT 2.9***	***Uncontrolled Diabetes 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-X]: Development of innovative evidence-based project for targeted diabetic population Metric 1:[P-X.1]: Document innovational strategy and plan Data Source: Performing Provider evidence of innovational plan Milestone 1 Estimated Incentive Payment (maximum amount): $1,127,581	Milestone 2 [P-X]: Implement evidence-based innovational project for targeted diabetic population. (2 DOC Start) Metric 1 [P-X.1]: Document implementation strategy ,testing outcomes, and hiring documentation Data Source: Performing Provider contract or other documentation of implementation Milestone 2 Estimated Incentive Payment (maximum amount): $621,065 Milestone 3 [I-X]: Identify X number of patients in defined population receiving innovative intervention	Milestone 4 [I-X]: Identify X number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1: [I-X.1]: Number of patients reached with screening process and # of patient referred Goal: 100 Patients identified, referred, and receiving appropriate treatment Data Source: Documentation of target population reached, as designated in the project plan. Milestone 4 Estimated Incentive	Milestone 5 [I-X]: Identify X number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1: [I-X.1]: Number of patients reached with screening process and # of patient referred Goal: 150 Patients identified, referred, and receiving appropriate treatment Data Source: Documentation of target population reached, as designated in the project plan. Milestone 5 Estimated Incentive

	consistent with evidence-based model. Metric 1: [I-X.1]: Number of patients reached with screening process and # of patient referred Goal: 50 Patients identified, referred, and receiving appropriate treatment Data Source: Documentation of target population reached, as designated in the project plan. Milestone 3 Estimated Incentive Payment (maximum amount): $621,065	Payment (maximum amount): $1,245,741	Payment (maximum amount): $1,029,091
Year 2 Estimated Milestone Bundle Amount: $1,127,581	Year 3 Estimated Milestone Bundle Amount: $1,242,130	Year 4 Estimated Milestone Bundle Amount: $1,245,741	Year 5 Estimated Milestone Bundle Amount: $1,029,091
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $4,644,543			

Identifying Project and Provider Information:
Project Title: MCHS Palliative Care Program
Unique Category 2 Identifier: 135235306.2.6
Project Category: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Performing Provider: Medical Center Health System TPI: 135235306

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): This project will develop and implement a palliative care team at Medical Center Health System. Focus will be on removing some of the stigmas surrounding palliative care for not only patients, but providers as well. We will use DY2 to develop the program and from there we will move into the implementation phase.
- Need for the project: Medical Center Health System has traditionally left palliative care to the rotating hospice providers and a few key physician stakeholders. While this has traditionally proven to be mildly effective, we understand that the need for palliative care is greater than ever considering the growing strains on our national health care system. According to the American Journal of Respiratory and Critical Care Medicine "Over 25% of healthcare costs are spent in the last year of life and approximately 20% of deaths occur in the ICU (Curtis, 2012)".
- Target population: The target population is our patients that need palliative care consults. Initial focus has revolved around Cancer, Cardiac, and Trauma patients. For the indigent and Medicaid population, a program like this is essential for smooth transitions. Having a resource like the Palliative Care Team would be essential to helping that population navigate a confusing period of time. Also, considering health disparities in the Medicaid population versus the insured population, it can be assumed that these types of services would be utilized more often in that population. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: Increased number of palliative care consults year over year beginning in DY3. Robust education program that helps to increase knowledge in regards to palliative care and its purpose. Our initial focus will be on creating an alert system that will be activated during Level 1 Trauma alerts. As the program expands and more physicians become comfortable with the service, we expect Cancer and Cardiology service lines to utilize the service on a more regular basis. In DY3 we expect to consult 648 patients and families, a 10% increase in DY4 to 713 consults, and a 20% increase in DY5 to 778 consults.

- Category 3 outcomes: IT-13.6 our goal is to reduce the intensive care inpatient mortality rate by TBD% by the end of DY5. Baseline will be established during DY3.

Project Specifics:

Over the course of the next 4 years, MCHS plans to create a more robust palliative care program for our community. We will do this in 4 main steps:

1. Create a business case for the palliative care program. This will take place over the course of DY2. The project team will include members representing: administration, nursing, physicians (Cancer, Intensivists and Palliative Care), chaplains, social workers, and hospice providers.

2. Create a patient/family experience survey. Again, this will be coordinated through the same project team including our Service Excellence Coordinator. This survey will be vetted and administered during DY2 to establish a baseline.

3. Implement the newly created Palliative Care Program. Our initial thought is that this team would include 3-4 people consisting of 2 nurses, a social worker, and a rotating chaplain. A Palliative Care Medical Director would also be chosen to provide oversight. A central part of this team's function would be to better coordinate with Home Health Agencies and Hospice Care. An expectation will be to have quarterly meetings with these agencies to cure inefficiencies and foster a cooperative relationship that serves the population.

4. After the team is in place, not only will they be responsible for coordinating care inside the hospital, they will also need to coordinate educational sessions with different outside stakeholder groups. It is our belief that eliminating the stigmas that surround palliative care, will enable a smoother process once in the facility. They will be responsible for coordinating 3 sessions per year starting in DY 4.

A few things that MCHS will expect this team to do are:

- Provide relief from pain, shortness of breath, nausea, and other distressing end of life symptoms
- Affirm life and regard dying as a normal process;
- Intend neither to hasten nor to postpone death;
- Integrate the psychological and spiritual aspects of patient care;
- Offer a support system to help patients live as actively as long as possible;
- Offer a support system to help the family cope;
- Use a team approach to address the needs of patients and their families;
- Will enhance the quality of life;

- Program is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy.

Relationship to RHP 14 goals

RHP 14 is committed to providing compassionate, coordinated care to all of our residents. Palliative Care in this region has been weak over the years and with a renewed focus by MCHS and MMH, we are hoping to change that. This project will affect the entire region due to the fact that many patients that require palliative care from outlying counties get the majority of their care at one of the larger facilities.

5-Year Goals

- Establish palliative care program that removes barriers and stigma associated with topic
- Establish MCHS as a regional leader in palliative care best practices.
- Reduce the amount of patients admitted to the ICU within the last 30 days of life.

Starting Point/Baseline Data (if applicable)

Currently we have a very basic program that is more based around accounting codes than care. We have a few outside consultants, but that is an unreliable practice at best.

Rationale:

This project meets CN10 as identified in the RHP 14 Needs Assessment.

Medical Center Health System has traditionally left palliative care to the rotating hospice providers and a few key physician stakeholders. While this has traditionally proven to be mildly effective, we understand that the need for palliative care is greater than ever considering the growing strains on our national health care system. According to the American Journal of Respiratory and Critical Care Medicine "Over 25% of healthcare costs are spent in the last year of life and approximately 20% of deaths occur in the ICU (Curtis, 2012)".

Related Category 3 Outcome Measure(s):

IT 13.6 Intensive Care-In hospital mortality rate (NQF 0703)

MCHS serves as the primary Level III/II trauma center for the Permian Basin and in that role it is essential that we take the lead on innovative palliative care practices. Up to 30% of our patients are not from Ector County, which means that we are often their only source for this type of care information. It is imperative that we work with the rural communities on making patients comfortable, both physically and spiritually, during a very difficult time for them and their families.

This metric is particularly important for our to us as a system, because at this moment we really don't have any controls in place to make sure that patients who are in the last stages of life aren't in the ICU receiving unnecessary treatments. This type of admission severely burdens the overall costs of healthcare and can affect our ability to put recoverable patients in those beds.

Relationship to other Projects

This project will correlate strongly with two main projects:

1. Care Transitions (135235306.2.2) - This project will help to identify potential patients that will need a palliative care consult from the proposed team. Proper identification and a quick consult will not only help the patient, but the family as well during their decision making process.

2. Faith Based Community Health (135235306.2.8) – Community outreach and education will be crucial in determining the overall success of the Palliative Care Program. Working with the local faith communities will allow us to have a platform to educate at risk populations about palliative care and its role. Eliminating some of the pre-conceived notions about palliative care will make conversations easier moving forward.

Relationship to Other Performing Providers' Projects in the RHP:

There is not a specific correlation between any other projects, but Midland County Hospital District will also be implementing a palliative care program, therefore opportunities to share best practices will be available.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the palliative care project was deemed to be our 6th most pressing project and therefore was given the 6th highest allocation.

Milestones and Metrics Table

135235306.2.6	***2.10.1***	***2.10.1 (A-D)***	***MCHS PALLIATIVE CARE PROGRAM***
PERFORMING PROVIDER MEDICAL CENTER HEALTH SYSTEM		***TPI 135235306***	
RELATED CATEGORY 3 OUTCOME MEASURE(S):	***135235306.3.10***	***IT 13.6***	***INTENSIVE CARE-IN HOSPITAL MORTALITY RATE (NQF 0703)***
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-1]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program Metric 1:[P-1.1]: Business Case Submission Data Source: Business Case write-up; documentation of planning activities Milestone 1 Estimated Incentive Payment (maximum amount): $530,394 Milestone 2 [I-12]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time Metric 1 [I-12.1]: Survey developed	Milestone 3 [P-5]: Implement a palliative care program Metric 1 [P-5.1]: Implement Comprehensive palliative care program Data Source: Charter for palliative care program; operational plan; palliative care team and hiring agreements Milestone 3 Estimated Incentive Payment (maximum amount): $578,631 Milestone 4 [P-8]: Document the conditions for which palliative care is consulted. Metric 1 [P-8.1]: Breadth of conditions for which palliative care is utilized. Goal: Determine which conditions are	Milestone 5 [P-6]: Increase the number of palliative care consults Metric 1: [P-6.1]: Palliative care consults meet targets established by the program Goal: 10% increase over initial DY 3 Baseline (Baseline of 648) Data Source: EHR Milestone 5 Estimated Incentive Payment (maximum amount): $386,876 Milestone 6 [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	Milestone 9 [P-6]: Increase the number of palliative care consults Metric 1: [P-6.1]: Palliative care consults meet targets established by the program Goal: 20% increase over initial DY 3 Baseline (Baseline of 648) Data Source: EHR Milestone 9 Estimated Incentive Payment (maximum amount): $319,594 Milestone 10 [I-12]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time

and implemented Data Source: Patient/Family Experience Survey Milestone 2 Estimated Incentive Payment (maximum amount): $530,394	being referred and what holes exist in program. Data Source: EHR Milestone 4 Estimated Incentive Payment: $578,631	palliative care Goal: 3 Sessions by end of DY 4 Data Source: Provide training and education curriculum Milestone 6 Estimated Incentive Payment (maximum amount): $386,875 Milestone 7 [I-11]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care Metric 1: [I-11.1]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter. Goal: TBD% increase Data Source: EHR Metric 2 [I-11.2]: Pain assessment (NQF-1637) - Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.	Metric 1 [I-12.1]: Survey developed and implemented. Scores increased over initial DY 2 baseline by 15% Data Source: Patient/Family Experience Survey Results Milestone 10 Estimated Incentive Payment (maximum amount): $319,592 Milestone 11 [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 Goal: 3 Sessions by end of DY 5 Data Source: Provide training and education curriculum Milestone 11 Estimated Incentive Payment (maximum amount): $319,592

		Goal: TBD % increase Data Source: EHR Milestone 7 Estimated Incentive Payment: $386,875	
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $1,060,788	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,157,262	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $1,160,626	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $958,778
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $4,337,454			

Identifying Project and Provider Information:
Project Title: Faith-Based Community Health
Unique Category 2 Identifier: 135235306.2.7
Project Category: 2.6.3- Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Performing Provider: Medical Center Health System TPI: 135235306

Project Description:

- Provider: Medical Center Health System is a multi-site health system anchored by Medical Center Hospital a 402-bed hospital in Odessa, TX. MCHS has a service area of 38,000 square miles, which covers 17 counties and almost 390,000 lives.
- Intervention(s): The establishment of a Congregational Health Network and the employment of a Faith Community Navigator would effectively bridge the professional care system and the local church. The role of the Navigator would be that of a health educator and teacher to promote healthy lifestyles and help people understand the relationships between lifestyle, faith and well-being. Liaisons MCHS would identify a registered nurse to serve as the Faith Community Navigator and be employed by the hospital.
- Need for the project: The overall health of the general population of Odessa and Ector County reflects an alarming increase in the diagnosis of chronic diseases. Often times, health issues are poverty based leading to patients seeking care in the emergency room, having waited too long to seek treatment from other avenues. After a temporary fix, patients go home only to return to the ER after not seeking the necessary follow up to stay well.
- Target population: The target population is varied. Our hope is that we will have access to all types of churches, which should encompass all types of payers from Medicaid to the uninsured. The initial focus will revolve around ensuring that all "at risk" patients have primary care physicians and have received their proper screenings. Medicaid/Indigent patients will be an essential focus of this project. MCHS serves as the safety net hospital for Ector County and about 40% of Ector County's population is either uninsured or on Medicaid.
- Category 1 or 2 expected patient benefits: Patients enrolled in the CHN would have access to multiple education resources and would have an advocate that could help them navigate an increasingly complex system. Once our advisory panel is set, we will be able to determine the amount of churches we want to enroll each year, but our initial goal would be to enroll a minimum of 500 members per year. Numbers could vary depending upon initial community response. First reactions have been very positive to the aspects of the program. The Odessa community has over 120 houses of worship and the long term goal would be to get congregation enrolled in the program.

- Category 3 outcomes: IT-12.1, 12.3, 12.4 our goal is to increase the number of screenings in three main categories.
    - Breast Cancer
    - Colorectal Cancer
    - Pneumonia Vaccine in Older Adults
- Continuous Quality Improvement: MCHS has a robust CQI plan in place to consistently challenge protocols in order to improve. For this project, we will work with internal and regional stakeholders to perform rapid cycle tests that will improve processes by exposing holes in our program. The region will meet quarterly and the MCHS FBCC team will meet on a monthly basis.

The overall health of the general population of Odessa and Ector County reflects an alarming increase in the diagnosis of chronic diseases. Often times, health issues are poverty based leading to patients seeking care in the emergency room, having waited too long to seek treatment from other avenues. After a temporary fix, patients go home only to return to the ER after not seeking the necessary follow up to stay well. MCHS recognizes that healthcare can be improved and access can be increased by engaging the local faith community as a partner. The establishment of a Congregational Health Network and the employment of a Faith Community Navigator would effectively bridge the professional care system and the local church. The role of the Navigator would be that of a health educator and teacher to promote healthy lifestyles and help people understand the relationships between lifestyle, faith and well-being. MCHS would identify a registered nurse to serve as the Faith Community Navigator and be employed by the hospital. They would be responsible for improving connectional relationships between the hospital and the community by providing a continuity of care to the area congregations. Working with the Navigator would be the liaisons representing the individual churches.

There are more than 120 churches in the Odessa area covering a wide variety of denominations and faiths. By identifying, linking and engaging local congregations with the healthcare system, a trusted partnership would result. A Congregational Health Network would effectively link the hospital with the faith communities and integrate the practice of faith with healthcare to care for the whole person and thus improve the health of the community. Additionally, this health and faith collaboration would result in improved quality of care, enhanced clinical outcomes, and support and resources to clergy and congregations. The end product of the Congregational Health program would be to improve the well-being of the individual before, during and after a hospital experience resulting in a reduction in mortality, and a reduction in hospital readmissions.

Project Specifics:

- Identify, link and engage local church congregations in the healthcare system
- Provide support and resources to clergy and congregations
- Enhance patient experience, both inside and outside the hospital; improve quality of care

- Demonstrate a reduction in hospital readmissions and mortality rates among members of the Congregational Health Network

Year 2:

- Identify local churches to participate
- Identify key leaders within the faith community to develop a Congregational Health Network Advisory Board
- Develop policy and procedures for the establishment and implementation of a Congregational Health Network
- In cooperation with IT, develop measurement tools and establish baselines for readmission and mortality data
- Develop Congregational Health Network program and educational materials
- Establish evaluation criteria to be implemented on a six month basis
- Begin presenting program to local church congregations
- Create the hospital employed position of Faith Community Navigator. Prepare job description with plans to employ in plan year 3.

Year 3:

- Hire Director of Community Health
- Introduce Congregational Health Network program to selected hospital departments through in service and educational opportunities.
- Continue to present Congregational Health Network to local church congregations
- Develop Faith Community Liaison volunteer job description and training program.
- With the assistance of local clergy, identify Faith Community Liaisons; provide orientation and training
- Begin enrolling congregants from identified churches
- Evaluate need for additional staff and budget for plan year 4.

Year 4:

- Continue to present Congregational Health Network to local church congregations and enrolling congregants
- Begin conducting analysis on collected data
- Using collected data, identify disease specific issues within targeted congregations
- Implement education programs within targeted congregations in response to identified health issues
- Evaluate need for additional staff and budget for plan year 5.

Year 5:

- Continue to present Congregational Health Network to local church congregations and enrolling congregants
- Continue analyzing collected data
- Provide health education programming based on identified health issues within congregation

Relationship to Region 14 Goals

RHP 14 is committed to expanding health literacy in our region. MCHS feels that the Faith Based Community Care program will help us achieve that goal.

5 Year Goals:

- Establish a Congregational Health Network that can serve as a primary site for health literacy and patient navigation.
- Increase the % of Women ages 40 to 69 receiving mammograms by TBD%
- Increase the % of adults ages 50 to 75 undergoing colorectal cancer screening by TBD%
- Increase the % of patients above 65 that receive the pneumonia vaccine by TBD%

Challenges/Issues:

- General scope of the project, logistics could be challenging
- Educating and training liaisons to ensure that they have the proper knowledge
- Setting baselines that are achievable considering the lack of accurate data

Starting Point/Baseline Data (if applicable)

New Program

Rationale:

- **This project meets CN1 and CN5 as identified in the RHP 14 CNA.**

This project made it through to our final project because we feel that it meets numerous community needs. Health literacy is extremely low in West Texas. Many of our residents don't have access to health information and therefore they don't receive the proper screenings the need to assure long-term health. This project will help MCHS continue its efforts to take care to the patient, as opposed to waiting on them to show up in our waiting room. This project presented numerous opportunities to reach patients that we haven't before, in an innovative manner.

Related Category 3 Outcome Measure(s):

- **IT-12.1 Breast Cancer Screening**

- **IT-12.3 Colorectal Cancer Screening**

- **IT-12.4 Pneumonia vaccination status for older adults**

Relationship to other Projects

Direct correlation to the Care Transitions project in that they will share a director to ensure consistency in community navigation.

Relationship to Other Performing Providers' Projects in the RHP:

No direct correlation

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

MCHS used a basic valuation tool to measure the effect of each project. The tool was centered on 4 main questions:

1. Does the project meet the waiver goals?
2. Does the project address a pressing community need?
3. Which population is being served?
4. What is the project investment (Resources needed)?

After consulting with local stakeholders, the Faith Based Community Care project was deemed to be our 8th most pressing project and therefore was given the 8th highest allocation.

Milestones and Metrics Table

135235306.2.7	***2.6 Implement Evidence Based Health Promotion Programs***	***2.6.3- Engage community health workers in an evidence-based program to increase health literacy of a targeted population.***	***Faith-Based Community Health***
Performing Provider Medical Center Health System		***TPI 135235306***	
Related Category 3 Outcome Measure(s):	***135235306.3.11 135235306.3.12 135235306.3.13***	***12.1 12.3 12.4***	***Breast Cancer Screening Colorectal Cancer Screening Pneumonia Vaccination Status for older Adults***
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-2]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community Metric 1: [P-2.1]: Document innovational strategy and plan. Data Source: MCHS evidence of innovational plan Milestone 1 Estimated Incentive Payment (maximum amount): $905,201	**Milestone 2 [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: Hire Director of Community Health position Data Source: Documentation of implementation Milestone 3 Estimated Incentive Payment (maximum amount): $493,763 **Milestone 3 [P-4]**: Execution of a learning and diffusion strategy for testing, spread and sustainability of	**Milestone 4 [I-6]:** Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model**.** Metric 1: [I-6.1]: Number of patient enrolled in CHN Goal: 625 Additional Patients enrolled in CHN Data Source: Patient Record Milestone 4 Estimated Incentive Payment (maximum amount): $990,397	**Milestone 5 [I-6]:** Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1: [I-6.1]: Number of patient enrolled in CHN Goal: 750 additional Patients enrolled in CHN Data Source: Patient Record Milestone 5 Estimated Incentive Payment (maximum amount): $818,154

	best practices and lessons learned. Metric 1: [P-4.1]: Document learning and diffusion strategic plan Data Source: Documentation of implementation. Milestone 2 Estimated Incentive Payment (maximum amount): $493,763		
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $905,384	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $987,526	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $990,397	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $818,154
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $3,701,461			

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program: Decreasing Frequent Flyers in ED through EMS Patient Navigation Program

Unique Project ID: 136143806.2.1

Performing Provider Name/TPI: Midland Memorial Hospital / TPI: 136143806
In collaboration with City of Midland EMS

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Memorial Hospital** is one of the 3 major hospitals in RHP14 and the only acute care hospital in Midland County-- estimated population of 144,500. MMH is a 320-bed not-for-profit acute care facility which provides inpatient and outpatient services to all the counties in RHP14. State data shows that approximately 25% of its inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery). **City of Midland Fire Department** operates EMS services out of 6 of its 9 stations, covering over 900 square miles and had over 12,000 EMS calls in 2012, with an average transport rate of 70%. In 2011, 49.8% of transports were Medicare/Medicaid patients and 31.2% uninsured.
Clearly state intervention(s)	Integration of 68NURSE (telephonic triage service) and an APRN on the EMS team resulting in fewer EMS transports and ED visits for non-emergent reasons.
Brief description of need for the project including appropriate data	Over a third of Midland's EMS transports are for non-emergent reasons. In 2012, the EMS averaged 8,375 non-emergent calls and 5,663 non-emergent transports. Our goal is to decrease this amount by 15-20% annually through ambulance-based APRN care or screening via 68NURSE. The APRN will serve as a patient navigator to provide onsite treatment, education and referrals to primary or preventive care providers.
Target pop. – # of patients served – how Medicaid and/or indigent patients benefit from project	In RHP 14, 19% of children and 32% of adults are uninsured and often do not seek preventative and primary care except through the ED, and/or only seek treatment when conditions have worsened to an acute level. Plan development will include a review of ED records to isolate zip code(s) with a predominance of non-emergent, frequent-flyers.
Category 1 or 2 expected patient benefits	Anticipate reducing non-emergent ED EMS runs: DY3= 500-700, DY4=700-900 and DY5=800-1,000, resulting in an accumulative total of 2,100-3,000 fewer, unnecessary ED visits for the entire demonstration period.
Category 3 outcomes	IT-11.1 – Improvement in Clinical Indicator in identified disparity group - Decrease the number of ED visits for non-emergent patients with diabetic complications by percentage to be established as part of this initiative and re-route them to a more appropriate venue such as the FQHC for medical supervision or MMH's Diabetic and Nutrition Learning Center.
CQI element(s)	CQI projects will include evaluation of disease management, ED utilization for identified frequent users, and expansion into other chronic disease diagnoses. This information will be reviewed and reported bimonthly to the EMS Committee and Fire Department QA Council

- **Project Description:**

Over a third of our City' EMS transports are for non-emergent reasons. According to RHP14's Community Needs Assessment, 19% of children and 32% of adults are uninsured, meaning that they often do not seek preventive and primary care except for care through the ED, and/or only seek treatment when their conditions worsened to an acute level. Our ultimate goal is to reduce preventable hospitalizations by using the 911 System to navigate these individuals into the existing health system. By bringing primary care to the targeted population and assisting them to interface with such outreach efforts as 68Nurse and the collaborative diabetic project of MMH, Midland Community Healthcare Services and City of Midland Health Department, our project assists RHP14 in achieving important regional healthcare goals including primary care access; managing chronic disease; and prevention of unnecessary ED visits, hospital admissions, and re-admissions.

We believe that by (1) developing and implementing a collaborative agreement between the 68NURSE program and EMS for telephonic triage services for non-emergent patients and by (2) collaborating with the local EMS to integrate an APRN on the EMS team, we can lower this rate by providing definitive care on site or by redirecting non-emergent patients to a more appropriate level of care.

For many of these non-emergent patients, the EMS is simply a means of transportation to a long wait in an inappropriate setting for primary care. Using the 68Nurse program along with an APRN on selected EMS teams in targeted areas of high inappropriate use, we can work to (1) increase access to primary care [CN.3] conveniently at a patient's point of origin [CN.6]; and (2) educate and refer people to the most appropriate site of care, thereby possibly increasing utilization of preventive care services and screenings [CN.5], which may result in lowering the high rate of chronic disease, particularly diabetes [CN.1], and its associated complications which usually lead to costly hospitalizations [CN.2]. Non-emergent patients calling EMS for transport will receive services of 68NURSE to reduce non-emergent ED visits and provide resources for appropriate level of care sites. Our goal by the end of the demonstration project is to achieve a 15-20% annual decrease (700-1000 transports per year) in non-emergent EMS transports to the ED through on-site APRN care or screening to a more appropriate level of care.

Using the core requirements as minimal guidelines, we will in—

a) DY2: 1. Work to identify frequent ED users by zip and/or census tract using ED patient records, so that we know where best to deploy our resources and be able to monitor continued usage of the ED by frequent flyers. 2. Assure both the ED and EMS staffs undergo annual cultural competency training. 3. Use both the 911 operators and 68Nurse staff as patient navigators. Using established protocols, the 911 operator will determine the appropriateness of sending an ambulance or connecting the caller with 68NURSE. If connected to 68NURSE, the caller will be triaged and navigated to the most appropriate level of care.

b) DY3-5: Place APRNs on selected EMS teams and link 68NURSE and its telephone triage capabilities with the EMS;
c) DY3-5: Connect non-emergent patients to 68NURSE and redirect them to more appropriate levels of care. Where appropriate, deliver primary care on-site via an EMS/APRN team dispatched to the patient.
d) DY3-5: Refer appropriate candidates with diabetes to MCHS and MMH's Diabetes Management Self-Training program.
e) DY3-5: Implementing Continuous Quality Improvement activities as specified below.

Our challenges include (1) transparency by both agencies to develop a successful partnership, (2) additional staffing for 68NURSE due to increased utilization and (3) patients' lack of compliance with triage decisions. The sincere desire by both MMH and the City of Midland to afford the best utilization and cost effective use of this community's EMS and medical resources will ensure a successful collaboration. We are looking at various ways to attract staffing – one of the thoughts is to attract retired RNs to work part-time. Changes may be met with resistance, but hopefully as awareness grows in the Community about the new options, patients and their families will be more receptive to complying with triage decisions.

Continuous quality improvement aspects will include monthly monitoring of patients receiving care on site or referrals to more appropriate levels of care. This information will be reviewed and reported to the Emergency Services Committee and Midland Fire Department QA Council.

- **Starting Point/Baseline:**

In 2012, the City of Midland's EMS received 8,375 calls that were classified as "for non-emergent reasons". Of these, they transported 5,663 (67.6%) of them to the Emergency Department. That was an average of 15.5 transports a day for non-emergent reasons to the ED, adding to the crowding in waiting rooms and increasing the throughput time.

- **Rationale:**

Within the city of Midland there is inefficient utilization of EMS services due to lack of available resources. Non-emergent patients use the EMS service for transportation, which could be addressed by providing onsite care or redirection to appropriate levels of care. To improve the efficiency of EMS transports and utilization of ED services, a collaborative agreement between City of Midland EMS and the 68NURSE program could provide onsite telephonic resources to divert non-urgent care patients from the Emergency Department to more appropriate locations. In addition to this agreement, another enhancement would include adding an Advanced Practice RN to EMS services to provide definitive onsite care to decrease non-emergent ED visits and increasing capacity for patients with emergent conditions. This project will address inefficiencies affecting cost, patient satisfaction, and overall health outcomes.

- **Related Category 3 Outcome Measure(s):**

  OD-11. IT-11.1. Improve clinical indicator in an identified disparity group. Providing direct definitive care on site by APRNs will decrease ED visits for non-emergent patients with diabetic complications and redirect them to a collaborative program with the local health department and FQHC to learn better diabetic management skills.

- **Relationship to other Projects:**

  Project 2.9.1 supports and will reinforce the effectiveness of Project (68Nurse) [Project 136143806.1.2] which directs patients seeking primary care providers by giving them another outlet for reaching individuals who utilize the ED.

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

  Although similar in thought, MMH's EMS APRN project [136143806.2.1] and Odessa Regional's Mobile Clinic [112711003.1.2], are uniquely different—whereas MMH's will serve Midland county residents, ORMC's will serve Ector county residents

- **Plan for Learning Collaborative:**
  RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

- **Project Valuation:**

  The valuation of each MMH project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community (especially in the hospital ICU) by addressing potentially preventable hospitalizations. Between 2005 and 2010, potentially preventable hospitalizations led to over 24,000 patient visits and resulted in approximately $461 million in charges. These conditions cause severe health consequences, waste patient time, and waste limited health resources. This is an imperative reform when considered in light of patient health outcomes and quality/quantity of life. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run, making it a high value project.

136143806.2.1	*2.9.1*	*2.9.1 (A-E)*	**Decreasing Frequent Flyers in ED through EMS Patient Navigation Program**	
Midland Memorial Hospital				***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.6***	***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-5. Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. By end of DY2, Midland Memorial Hospital will have developed and implemented a collaborative working agreement with City of Midland EMS services to provide on-site access to 68NURSE services to assist in decreasing non-emergent ambulance transports and identified the patient population(s) to be targeted by the navigator program Metric P-5.1. Collect and report on all the types of patient navigator services provided. Provide report identifying targeted patient population characteristics of frequent ED utilization along with how program with identify and manage target population (policies and procedures, service maps) Data Source EHR and claims system	Milestone 2 P-5. Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. By end of DY3, Midland Memorial Hospital will have researched and developed a pilot program to provide APRN presence on EMS units to decrease non-emergent ED transports and redirection to the appropriate level of care thereby reducing non-emergent ED transports to the ED by as much as 500-700 transports for the year. Metric P-5.1. Collect and report on all the types of patient navigator services provided. Provide report showing expansion and enhancement of navigation program to provide primary care at point of contact if appropriate Data Source P-5.1.a EHR and claims system	Milestone 3 I-8. Milestone: Reduction in ED use by identified ED frequent users receiving navigation services. By the end of DY4, Midland Memorial Hospital will have implemented the pilot program to provide an APRN on defined EMS units to evaluate impact on decreasing non-emergent ED transports and to redirect patients to the appropriate level of care. Non-emergent ED transports will decrease by as much as 700-900 of total non-emergent transports for the year. Metric I-8.1 Difference in total number of ED visits pre and post navigation services by individuals identified as ED frequent users. Data Source I-8.1.b EHR and claims system Milestone 3 Estimated Incentive Payment: $522,061	Milestone 4 I-8. Milestone: Reduction in ED use by identified ED frequent users receiving navigation services. By the end of DY5, Midland Memorial Hospital will continue the pilot program to provide an APRN on defined EMS units to evaluate impact on decreasing non-emergent ED transports and to redirect patients to the appropriate level of care. Non-emergent ED transports will decrease by as much as 800-1000 of total non-emergent transports for the year. Metric I-8.1. Difference in total number of ED visits pre and post navigation services by individuals identified as ED frequent users. Data Source I-8.1.b EHR and claims system Milestone 4 Estimated Incentive Payment: $412,697

136143806.2.1	*2.9.1*	*2.9.1 (A-E)*	**Decreasing Frequent Flyers in ED through EMS Patient Navigation Program**
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.6***	***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 Estimated Incentive Payment *(maximum amount):* $650,663	Milestone 2 Estimated Incentive Payment: $665,473		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $650,663	Year 3 Estimated Milestone Bundle Amount: $665,473	Year 4 Estimated Milestone Bundle Amount: $522,061	Year 5 Estimated Milestone Bundle Amount: $412,697
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,250,894			

Project Option 2.2.6 – Expand Chronic Care Management Model – Tackling Community Diabetes
Unique Project ID: 136143806.2.2
Performing Provider Name/TPI: Midland Memorial Hospital /TPI: 136143806
In collaboration with City of Midland Health Department and
Midland Community Healthcare Services (local FQHC)

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**City of Midland Health Department** provides immunization and screening/ treatment of sexually transmitted infections for the populace of Midland County and anyone else seeking these services, regardless of ability to pay. **Midland Community Healthcare Services** (MCHS) has been an FQHC since 2006. MCHS sees over 14,000 individual patients via 60,000 office visits annually. **Midland Memorial Hospital (MMH)** is one of the three major hospitals in RHP14 and the only acute care hospital in Midland County—est. population of 144,000. MMH, a 320-bed not-for-profit acute care facility, provides inpatient and out-0 patient services to all the counties in RHP14. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery). MMH's **Diabetes and Nutrition Learning Center** (DNLC) provides a comprehensive diabetes self management program (DSMT).
Clearly state intervention(s)	Diabetes screenings for diagnosis, HbA1c control and foot exams can identify undiagnosed or inadequately treated diabetic patients, referring them to MCHS and MMH for treatment and education.
Brief description of need for the project including appropriate data	Extrapolating data based on the CDC diabetes statistics and our Community Needs Assessment (CNA), there are over 14,000 people with diabetes in Midland County—~ 3,900 are undiagnosed. FY2012, MMH had over 2,200 inpatient admissions and just over 4,700 ED visits for patients with diabetes diagnoses. Financial issues limit access to care for many of the uninsured and undertreated. The CNA identified our region, as compared to Texas, as having a higher percentage of adults not accessing basic preventive care due to lack of education and cost barriers [CN5 & CN7].
Target pop. – number of patients served – how Medicaid and/or indigent patients will benefit from project	The target population is adults with diabetes--either undiagnosed or untreated due to lack of education or cost barriers. By creating alternative venues for screening such as the MHD and neighborhood fairs, our goal is to reduce the number of undiagnosed and/or currently unsupervised cases in Midland County who seek costly, sporadic medical services in the ED or end up hospitalized. The collaborative efforts of MHD, MCHS and MMH will help ensure our Medicaid and uninsured patients gain access to evidence-based care and education.
Category 1 or 2 expected patient benefits	Earlier diagnosis and referral for treatment of type-2 diabetes as well as diabetes education will lessen the long-term effects for a population who may have limited access to medical providers by the usual routes. We estimate 350 people will be screened during year 2.
Category 3 outcomes	IT 1.10 - Diabetes Care: HbA1c Poor Control (>9.0%) and IT 1.13 - Diabetes Care: Foot Care - Enhance patient quality of life through early detection of diabetes with screenings and/or HbA1C tests thereby lessening the probability of diabetic complications as well as unnecessary ED and inpatient admissions.
CQI element(s)	Track/follow-up on referral appointments completed vs. referral appointments made. Track HbA1c and improve HbA1c after treatment and education.

- **Project Description:**

  Our goal is to reduce the number of undiagnosed and untreated cases of diabetes among the RHP uninsured and under insured populations as well as to influence patients through community-wide education on the many complications of diabetes, to enroll and participate in diabetic self-management training. By doing so, we hope to lower both the frequency of patients presenting at the local ED with diabetic complications and the number of hospital admissions for serious diabetic complications. Our major challenge is to develop and disseminate appropriate community-wide education which drives home the seriousness of diabetes and associated complications, the importance of screening and self-management.

  Midland Memorial Hospital and Midland Health Department in collaboration with Midland Community Health Care Services (a local FQHC) seek to pilot a program initially targeted at diabetes for Midland's underserved patient population who experience significant challenges to health and multiple concurrent medical conditions associated with poverty, language, cultural and psychosocial barriers. Midland Health Department and Midland Memorial Hospital will provide initial screenings and then referrals to MCHS for care and MMH for self-management training. The screenings will be conducted not only at the weekly Health Department but at other community centers and community events. We expect to screen 350 people in year 2. All screening will be conducted uniformly using evidence-based protocols. MMH Diabetes and Nutrition Learning Center (DNLC) will be able to take its DSMT program (8-10 hours of AADE certified education) to various sites including the Midland Health Department as well as faith-based and community centers. Studies show patients who undergo a DSMT program have, at a minimum, a 10% higher adherence and compliance rate with clinically appropriate, evidence-based medical treatments to improve their health outcomes. It also includes improvements in risk reduction behaviors, such as blood glucose monitoring. For 2012, 82% of the patients who completed the MMH DSMT program (3 classes and follow up) had an HbA1c of less than 7%. Research from the 1998 UKPDS study shows that a reduction in HbA1c lowers risk for amputation, microvascular complications, myocardial infarctions and all-cause mortality. There will be an intense community-wide education program aimed at depicting the multiple complications associated with uncontrolled diabetes.

  Pages 13-16 in the Community Needs Assessment, Sections “Health Outcomes” and “Summary Demand and Need for Services” note that diabetes was one of the leading causes of death in Texas in 2006, and in 2010, nearly 10% of Texas adults were diabetic. Of the 25.8 million people in the United States with diabetes, 7.0 million are undiagnosed. Using this data for Midland County, we estimate there are 14,000 people with diabetes and of those, 3900 are undiagnosed. According to the CDC, if current trends continue, 1 in 3 adults will have diabetes by 2050. Furthermore, the percentage of older adults in RHP 14 is expected to grow in the next twenty years which will result in an increase in chronic disease services, such as diabetes. [CN.1 – High rates of chronic disease, including cancer, diabetes, heart disease, cardiovascular disease, respiratory disease, Alzheimer’s and obesity; CH.5 – Low utilization of preventative care services, especially by those with lower incomes].

- **Starting Point/Baseline:**

  Of the three collaborators, two are currently working with diabetic patients. MCHS is currently managing an average of 1,000 patients with diabetes per year. MMH's DNLC is currently averaging 156 patients per year who complete the DSMT program—which is extremely low considering the size of our population. The Health Department is not currently managing or screening patients for diabetes.

- **Rationale:**

  The Planning Protocol states that the deficiencies in the current management of diseases such as diabetes. Our project hopes to minimize or eliminate these problems within our targeted population. We plan to address these deficiencies as follows:

  - ***Lack of care coordination***: The project will form a partnership among the 3 entities involved to ensure continuity.
  - ***Lack of active follow-up to ensure the best outcomes***: A diabetes registry will be created and the patients will be followed to improve glycemic control.
  - ***Inadequately trained patients:*** This project will provide a pathway to enroll patients in a certified DSMT program.

  This project also addresses community needs CN.1, CN.5 and CN.6 from our RHP14 Community Needs Assessment.

  - CN1. Our community has a high rate of diabetes. 10% of Midland County's population over age 19 have diabetes (assuming that Midland is commensurate with the rest of the RHP); the number of residents with pre-diabetes and/or at risk is likely to be significantly higher bases on a 29% rate of obesity in the RHP.
  - CN5. Our community has low utilization of preventative care services and screenings. Currently there is no coordinated effort to screen through HbA1c testing.
  - CN6. Our project will improve access to care by taking screening and culturally appropriate education to the underserved population

- **Related Category 3 Outcome Measure(s):**

  For DY2, the collaborative will be focusing on establishing baseline rates on what percentage of Health Department users agree to participate in pre-assessment and, depending on results, HbA1c and foot exam. For DY3-5, our outcome measures will be IT-1.10 (Diabetic care: HbA1c poor control) and IT-1.13 (Diabetes care Foot exam). Diabetic foot problems are fairly common problems among diabetics, are commonly neglected, and can lead to amputation and resultant disability. Early detection, treatment and self-management should lessen impact, both of frequency and severity of diabetic foot ulcers. We believe that the availability of screening and self-management training within the community provides a pathway to treatment for those who need it.

- **Relationship to other Projects:**

  1.1 Expand access to primary care – create a pipeline between health department and local FQHC and 2.6 Implement Evidence Based Health Promotion Programs – part of our public education campaign will interface with this project.

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

  Many of the providers taking part in the DSRIP initiative have diabetes projects. This proliferation of diabetes projects underscores the epidemic problem that diabetes presents for our RHP. Medical Center (Ector County) [135235306.2.5], like MMH's project, is teaming with the local Health Department to do diabetic outreach and education. Other providers proposing diabetes projects include McCamey (Upton County-09417602.2.1), Martin County (136145310.2.1). Reeves County Hospital District (112684904.2.1), Odessa Regional (Ector County-112711003.2.3) as well as TTUHSC (081939301.2.1 & 2.2). None of the other providers are targeting the Midland county population. Hopefully, with such a massive effort, our Region will be successful in impacting diabetes.

- **Plan for Learning Collaborative:**

  RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

- **Project Valuation:**

  The valuation of Midland Memorial's Chronic Care Management project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Midland Memorial will focus on improving treatment access for patients who might normally wait until manifestation of an emergent condition. This focus on improving access to care will also help improve quality of care, and the eventual outcomes related to follow-up treatment. These objectives are in line with the Waiver's overriding goals. Midland Memorial is targeting the 10% of local residents with diabetes and the 29% of residents with obesity, a marker for pre-diabetic conditions. Diabetes is currently the sixth leading cause of death in Texas and caused nearly 3,000 potentially preventable hospitalizations in RHP 14 between 2005 and 2010. As a result, this project will target a large segment of the region's population and impact a substantial number of people, particularly the region's uninsured and underinsured patients. This project is a good investment because of the widespread benefits of ongoing education and treatment. This project will also maximize the availability of local resources by referring patients to FQHCs.

136143806.2.2	*2.2*	*2.2.6*	**Expand Chronic Care Management Model**
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.7*** ***136143806.3.8***	***IT 1.10*** ***IT-1.13***	***Diabetes care: HbA1c poor control*** ***Diabetes care: Foot Exam***

Year 2 (10/1/2012 – 9/30/2013)	**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-9. Develop program to identify and manage chronic care patients needing further clinical intervention including data collection on public diabetes prevention education, screening and referrals to local FQHC and MMH for Diabetes Education. Projected # of screenings for year 2: 350	Milestone 2 I-21. Improvements in access to care of patients receiving chronic care management services using innovative project option. Increase screenings by 10% from the previous year. Increase referrals to DSMT and thereby increase number of patients completing the program.	Milestone 3 I-21. Improvements in access to care of patients receiving chronic care management services using innovative project option. Increase screenings by 10% from the previous year. Increase referrals to DSMT and thereby increase number of patients completing the program.	Milestone 4 I-21. Improvements in access to care of patients receiving chronic case management services using innovative project option. Increase screenings by 10% from the previous year. Increase referrals to DSMT and thereby increase number of patients completing the program.
Metric P-9.1. Documentation of number of patients identified as needing screening test, preventative tests, or other clinical services. # of pts. identified & given test # of patient identified	Metric I-21.1. Increase percentage of target population reached. # of patients reached by program # of individuals-target population	Metric I-21.2. Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Total # of unique patients encountered in the program for reporting period.	Metric I-21.2. Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Total # of unique patients encountered in the program for reporting period.
Data Source P-9.1.c. EHR, patient registry	Data Source I-21.1.d. Documentation of target population reached, as designated in the project plan.	Data Source I-21.2.b. Registry, EHR, claims or other Performing Provider source	Data Source I-21.2.b. Registry, EHR, claims or other Performing Provider source
Milestone 1 Estimated Incentive Payment *(maximum amount):*	Milestone 2 Estimated Incentive	Milestone 3 Estimated Incentive Payment: $1,305,153	Milestone 4 Estimated Incentive Payment: $1,031,742

136143806.2.2	*2.2*	*2.2.6*	**Expand Chronic Care Management Model**
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.7*** ***136143806.3.8***	***IT 1.10*** ***IT-1.13***	***Diabetes care: HbA1c poor control*** ***Diabetes care: Foot Exam***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$1,626,657	Payment: $1,663,683		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,626,657	Year 3 Estimated Milestone Bundle Amount: $1,663,683	Year 4 Estimated Milestone Bundle Amount: $1,305,153	Year 5 Estimated Milestone Bundle Amount: $1,031,742
TOTAL ESTIMATED DSRIP Funding for 4 Years *(add amounts of Estimated DSRIP Funding for years 2-5)**:*** $5,627,235			

Project Option 2.10.1 – Use of Palliative Care Programs: Integration of a Palliative Care Team into an Acute Care Hospital
Unique Project ID: 136143806.2.3
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Memorial Hospital** serves an estimated population of 144,500. MMH is a 320-bed not-for-profit acute care facility providing inpatient and outpatient services to all counties in RHP14. 25% of inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (does not include Nursery).
Clearly state intervention(s)	New program to integrate a palliative care consult team so patients with serious illness experience better quality of life by having supportive care to manage physical symptoms; psychosocial, cultural/spiritual concerns and to assist with decision-making. Support is provided for physicians and nursing staff by assisting with time-intensive patient/family conversations and ongoing education.
Brief description of need for the project including appropriate data	Most people with a serious illness experience inadequate treatment of symptoms, fragmented care, poor communication with providers and increased stress on family. Texas received a grade of 42% from the National Palliative Care Research Center. Palliative Care assists with difficult-to-manage symptoms, complex family dynamics and challenging care decisions regarding the use of life-sustaining treatments and it aligns patient/family goals and needs with the care being provided to the patient.
Target population – number of patients served – how Medicaid and/or indigent patients will benefit from project	Palliative Care can benefit patients with serious life-limiting illnesses. There is a geographic disparity in Palliative Care services in the State which includes Medicaid and/or indigent patients. Underserved patients tend to have more chronic illness and be more compromised due to lack of access to healthcare. Palliative care is 100% available to any Medicaid or indigent patient needing palliative care services. In FY 2012, approximately 1204 patients were possible candidates for palliative care based on DRGs. Medicaid, uninsured and Medicare patients made up over 80% of these cases.
Category 1 or 2 expected patient benefits	Based on current patient levels and available data, by DY3 at least 20-30% of patients with serious, life-limiting will be screened for palliative care. By DY4, the program will improve transition of palliative care patients out of the acute care setting into hospice, home care or other appropriate setting
Category 3 outcomes	IT 13.1 – Pain Assessment, IT 13.2—Treatment Preferences and IT 13.5 – Documentation in the clinical record of a discussion of spiritual/religions concern or documentation that the patient/caregiver did not want to discuss. Improve patient quality of life by measuring these outcomes in 80% of identified patients.
CQI element(s)	Metrics will be measured upon entry into palliative care services and upon discharge from the program. The following outcomes will be measured: (1) satisfaction, (2) improvement of physical symptoms, (3) treatment references and (4) documentation of spiritual/religious concerns. Metrics not meeting standards will be examined, changes made using PDSA cycle, and metrics re-evaluated.

- **Project Description:**

The Palliative Care Team consult service will be a center of excellence in the practice of palliative care medicine by improving the quality of life of patients with serious, life-limiting illnesses and by providing ongoing education so providers at MMH can better understand the complex nature of life-limiting illnesses and increase their level of comfort dealing with end-of-life issues.

A Palliative Care consultation service is designed to provide specialty level of care for difficult-to-manage symptoms, complex family dynamics and challenging care decisions regarding the use of life-sustaining treatments. The goal will be to establish a consultative palliative care program based on the initial business plan that works in conjunction with all units in the hospital to provide patients diagnosed with a serious life-limiting illness culturally appropriate end-of-life care. The palliative care team will work to minimize stressors and symptoms the patient may be experiencing in the physical, psychosocial, spiritual, and cultural domains. Incorporating patient desires, the palliative care team will assist in transitioning patients from an acute care environment into other environments such as home care, hospice or a skilled nursing facility to meet the desired outcomes of the patient. Outcomes will be measured throughout the program and will include a patient/family satisfaction survey with the goal of making the survey accessible in an electronic form for patient/family convenience. Quality improvement will be another important aspect of the program as the program seeks to improve patient and hospital outcomes. Texas ranks 44th in palliative care compared to the rest of the country. Even though access to palliative care has increased in the last several years, many individuals in Texas still do not have access to palliative care. [CN.10 – Increase Palliative Care Services]

Goals for the next 5 years —

- Palliative Care consult penetration will be at least 20% of potential cases (as identified by screening tool).
- Increase the number of patients who transition from acute care into home care, hospice or a skilled nursing facility.
- Improve patient/family satisfaction regarding symptom management and patient/family centeredness above initial baseline scores. This will be strengthened by ensuring patients' pain levels are assessed and treated, patients' treatment preferences are addressed and patients' spiritual/religious concerns are addressed.
- Improve quality of life for palliative care patients and their families

Improve cost-effectiveness of care provided to the patient during hospitalization

Our challenges are many but most especially this is a new program with clinical staff and providers not understanding the scope of the palliative care program. There will be some providers who will be resistant to changing their practice methodology. Much education will be required along with building trust between providers and the palliative care team.

- **Starting Point/Baseline:**

  Baseline data is zero since there is not a palliative care program in place. When we looked at the patient discharges in fiscal year 2012, approximately 1,204 were possible candidates for palliative care based on DRGs representing serious illnesses. We determined 20% of this population could result in a potential of 240 patients per year receiving palliative care services.

- **Rationale:**

  A palliative care program is needed in an acute care setting to improve the quality of life for patients and their families facing the issues associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of issues including physical, psychosocial and spiritual. Today's healthcare environment has seen an increase in the number of older patients with co-morbidities which results in a much sicker patient in the hospital setting. By 2030, 20% of the population will be over 65 (Morrison & Meier, 2004). Smith and Cassel, 2009, found the use of a palliative care team resulted in higher quality and lower costs due to control over the clinical care of the patient. Palliative care was also associated with fewer hospitalizations and fewer ICU hospital days. Smith and Cassel found randomized studies appear to show reduced costs for palliative care patients because of medically appropriate goal setting and matching resource use to the goal of care set by the patient and the palliative care team. Transitioning patients to the appropriate setting they desire to be in led to the decreased cost and higher patient and family satisfaction with the care they receive at end of life. A palliative care program lends itself to assisting the region meet its goals of increasing quality of care and improving cost-effectiveness of care provided in the community.

- **Related Category 3 Outcome Measure(s):**

  The Category 3 Outcome measures selected will be, IT-13.1 Pain assessment, IT- 13.2 Treatment Preferences and IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. The palliative care program is a holistic approach to helping the patient with a life-limiting illness. Palliative care has domains of care which consist of physical, psychosocial, spiritual and cultural. Controlling pain is very important to all patients. Uncontrolled pain leads to decreased quality of life and poorer patient satisfaction scores. The palliative care patient not only has to confront their serious illness, but also all the psychological/social issues that ensue. To lessen some of the emotional distress that occurs with serious illness, educating patient and family about the use of an advance care directive, and actually having a directive in place, will assist the patient and family when decisions need to be made. Assessing the spiritual needs of the patient is part of the mission of palliative care. Improved spirituality has been shown to be associated with decreased anxiety and depression, reduced mortality rates among cancer

patients and improved clinical outcomes such as improved pain and reduced length of stay (Clark, Drain & Malone, 2003).

- **Relationship to other Projects:**

  The palliative care program will incorporate quality improvement process and continually evaluate outcomes in an effort to improve the program. Palliative care considers the patient and the family as the care unit and provides assistance to any member who is in need. This holistic approach will lend itself to collaborate with other projects in the Regional Healthcare Partnership such as Patient Surveying and Subsequent Process Improvement and possible preventable hospital readmissions. The palliative care team consists of a mental health expert who will refer the patient or members of the family to mental health resources when needed. Possible preventable hospital readmissions will be possible because the palliative care team focus on minimizing and controlling patient symptoms. This should carry forward to their home environment and possibly prevent recurrent ER visits.

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

  We (Midland Memorial) and Medical Center (135235306.2.6) have projects that develop and integrate Palliative Care programs within their respective hospitals. While these projects serve distinct inpatient populations located 20 miles apart, they will present opportunities to collaborate on processes, successes and missteps through regular information sharing.

- **Plan for Learning Collaborative:**

  RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

- **Project Valuation:**

  The valuation of Midland Memorial's Palliative Care project uses a method which ranks the importance of each project based several key factors. First, Midland considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Midland considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Midland reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. For instance, this outcome domain is one of three outcome domains associated with Midland's palliative care project. Therefore, the value of this project varies in relation to the overall community benefit of the palliative care project. Palliative Care is an effective tool for meeting the needs of patient populations who are at risk of suffering from progressive illness. Studies have demonstrated that Palliative Care improves family satisfaction and patient quality of life while reducing symptom burden and costs associated with non-beneficial medical care. For this reason, many states are attempting to remedy the status quo through Palliative Care initiatives. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost savings, improved quality of life, and even prolongation of life. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial those savings can be used to further improve and expand supportive care for all patients.

References:

Clark, P.A., Drain, M., & Malone, M.P. (2003). Addressing Patient's Emotional and Spiritual Needs. Joint Commission Journal on Quality and Safety. 29(12), 659-670.

Morrison, R.S. & Meier, D.E. (2004). Palliative Care. New England Journal of Medicine, 350(25), 2582-2590.

Smith, T.J. & Cassel, J.B. (2009). Cost and Non-clinical Outcomes of Palliative Care. Journal of Pain and Symptom Management, 38(1), 32-44.

136143806.2.3	2.10.1	2.10.1(A-D)	Palliative Care Program
Midland Memorial Hospital			136143806
Related Category 3 Outcome Measure(s):	136143806.3.9 136143806.3.10 136143806.3.11	IT.13.1 IT.13.2 IT.13.5	Pain Assessment Treatment Preferences Documentation of Spiritual/Religious Concerns

Year 2 (10/1/2012 – 9/30/2013)	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. Implement/expand a palliative care program By the end of DY2, we will have implemented a palliative care program based on the business plan written in DY1. All documentation templates and program policies will have been approved and activated. Metric P-5.1. Implement comprehensive palliative care program Go Live date established and program begins to receive patient referrals. Documentation: Charter for Palliative Care program; Operational Plan; palliative care team and hiring agreements Data Source P-5.1.b. Data Source: Palliative Care Program Milestone 1 Estimated Incentive	Milestone 2 P-6. Increase the number of palliative care consults By the end of DY3, we will continue expansion of the palliative care program by increasing the number of patient consults resulting from the screening tool done upon admission. We anticipate a 10% increase from the potential 240 patients identified in the first year (DY2). Metric P-6.1. Palliative Care consults meet targets established by the program. Achieve at least 10% of patients with serious illnesses are being referred and screened as possible candidates for palliative care. Number of palliative care consults Target # of palliative care consults Data Source P-6.1.c. Palliative database	Milestone 3 I-9. Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with or without hospice services. By the end of DY4, we will have earlier identification and transition of palliative care patients needing home care, hospice, or a skilled nursing facility. Metric I-9.1. Transitions accomplished Achieve at least 10% of terminally ill palliative care patients being transitioned into home care, hospice or a skilled nursing facility. # of palliative care discharges to home care, hospice or SNF Total # palliative care discharges Data Source I-9.1.c Palliative care database	Milestone 4 I-9. Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with or without hospice services. By the end of DY5, we will have earlier identification and transition of palliative care patients needing home care, hospice, or a skilled nursing facility. Metric I-9.1. Transitions accomplished Achieve at least 20% of terminally ill palliative care patients being transitioned into home care, hospice or a skilled nursing facility. # of palliative care discharges to home care, hospice or SNF Total # palliative care discharges Milestone 4 Estimated Incentive

136143806.2.3	***2.10.1***	***2.10.1(A-D)***	***Palliative Care Program***
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.9*** ***136143806.3.10*** ***136143806.3.11***	***IT.13.1*** ***IT.13.2*** ***IT.13.5***	***Pain Assessment*** ***Treatment Preferences*** ***Documentation of Spiritual/Religious Concerns***

Year 2 (10/1/2012 – 9/30/2013)	**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: $894,661	Milestone 2 Estimated Incentive Payment: $915,026	Milestone 3 Estimated Incentive Payment: $717,834	Payment: $567,458
Year 2 Estimated Milestone Bundle Amount: $894,661	Year 3 Estimated Milestone Bundle Amount: $915,026	Year 4 Estimated Milestone Bundle Amount: $717,834	Year 5 Estimated Milestone Bundle Amount: $567,458
TOTAL ESTIMATED DSRIP Funding for 4 Years *(add amounts of Estimated DSRIP Funding for years 2-5)***:** $3,094,979			

Project Option 2.6.1 – Engage in population-based campaigns/programs to promote healthy lifestyles using evidence-based methodologies including social media/text messaging in an identified population: Evidence-based Health Promotion& Disease Prevention Programs
Unique Project ID: 136143806.2.4
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806

Summary	
Provider Description: Type, size & role in region's health care infrastructure	**Midland Memorial Hospital,** 1 of 3 major hospitals in RHP14 is the only acute care hospital in Midland County—est. population of 144,500. MMH is a 320-bed not-for-profit acute care facility providing inpatient & outpatient services to all the counties in RHP14. State data shows that approximately 25% of its inpatient activity comes from outside Midland County. In FY12, 19.3% of our total patient days were either Medicaid or Uninsured (not including Nursery).
Clearly state intervention(s)	Increase public education of general health and wellness as well as disease prevention by sponsoring community events based on common health disorders or needs discovered from local ED and community clinic data located in neighborhoods of greatest need as identified by zip code.
Brief description of need for the project including appropriate data	Needs Assessment identified our region,compared to Texas, as having a higher percentage of adults not accessing basic preventive care and routine lab work due as well as prenatal care to lack of education and cost barriers [CN5 & CN7]. Our ED has seen an increasing number of uninsured and underinsured patients presenting for primary care or potentially preventable disease.
Target population – number of patients served – how Medicaid and/or indigent patients will benefit from project	Through the review of ED and community clinic data we will target common preventable disease processes that create a burden on our hospital district through the lack of self-management by uninsured and Medicaid populations. We will track this population to specific neighborhoods where community health events will be hosted to educate as well as offer free basic health screenings such as glucose, blood pressure and lipid profiles. Payer mix by zip code data from 2011 shows 79701, containing roughly 7000 homes, as having the largest Medicaid and private pay/uninsured population (approximately 1000 residents) in our primary service area. Through this project, there is potential to reach at least 10% of this population, increasing each DY, thereby reducing inappropriate use of the ED for primary care, creating better disease management and decrease preterm birth and low birth weights.
Category 1 or 2 expected patient benefits	Percentage of at-risk population in targeted areas reached in DY3 and 4 will increase year as compared to DY2. By DY5, targeted populations reached will expand into secondary service areas, thus increasing the overall percentage as well as the demographics of at-risk residents reached by the project.
Category 3 outcomes	IT 11.1 – Improvement in Clinical Indicator in identified disparity group – Reduce the number of low income women who present for delivery with no prenatal care by a percentage to be established as part of this initiative.
CQI element(s)	Documentation of interventions, online and print surveys, as well as face to face evaluation sessions with said population will allow measurement of the project's impact and provide opportunity for quality improvement.

- **Project Description:**

Our project addresses both CN5 and CN7 [Low utilization of preventative care services and screening & Need for improvement in prenatal and perinatal care] as explained below. Our goal is to focus on population specific health education and awareness through various community partnerships by holding demographically targeted events and aid in the redevelopment of evidence-based programs such as Hope Chest [a program developed by the local March of Dimes[(1)] chapter to incentivize low income, expectant women to seek prenatal care by awarding points for each prenatal care visit that can be redeemed for baby merchandise] in an effort to promote proactive health screenings, early enrollment in prenatal care and reduction of childhood obesity among other health education components. These events will be based on common health disorders or needs discovered from local ED and community clinic data and strategically located in neighborhoods of greatest need as identified through a data breakdown by zip code. We will spotlight wellness, healthy lifestyles and disease self-management among populations most at risk or undereducated on such topics. These events will feature free health screenings such as blood pressure, glucose and lipid profiles, which are proven to aid in the awareness and engagement of individuals potentially at risk for various health disorders. We know through the community needs assessment that these preventative screenings are also often not utilized by our targeted demographic due to cost and accessibility. Through partnership with the local community health clinics we will also better educate the underinsured and uninsured on affordable access to healthcare in our region. By the end of DY5, in both our primary and secondary service areas, we hope to achieve an overall reduction in potentially preventable usage of the ED for primary care, create opportunities for better disease management and prevention through education and community screenings, and increase early enrollment in prenatal care thus reducing preterm birth and low birth weights. (See Community Needs Assessment, Sections on *Fertility and Natality* and *Health Outcomes*, pages 10-14.) Payer mix by zip code data from 2011 shows "79701" as containing roughly 7000 homes and having the largest Medicaid and private pay/uninsured population (approximately 1000 residents) in our primary service area. Through hosting a targeted health event in a zip code such as this one, there is potential to reach at least 10% of this population thereby creating better awareness and disease management and potentially reducing the burden on our hospital district due to inappropriate ED use and avoidable admissions by this demographic. This will also lead to less Medicaid and Medicare claims filed as a result of these unnecessary visits and admissions. Challenges include encouraging increased personal responsibility and self-accountability among

populations living at or near poverty level where meeting basic needs can become priority over health awareness and education. Determining the best method of communication to said population and creating effective incentives to encourage attendance are also expected to be challenging. We plan to combat and hopefully overcome these challenges through the strategy of incentivizing the targeted population with items that are known to be of value to them which will be discovered through both written and verbal surveys and research. We will also investigate best practices and most popular communication channels to said population to ensure we are reaching them in the most impactful and meaningful way.

As part of our continuous quality improvement efforts, we will measure the impact of our project by the ability to identify and connect, through the various communication mediums, to our targeted populations and show that they are more engaged in their healthcare than they were before our interventions. This will be proven through documentation of interventions, online and print surveys, and face to face evaluation sessions with said population.

- **Starting Point/Baseline:**

  In DY1, approximately 165 people in the targeted populations attended the 2 focused neighborhood health fairs, each of whom received some form of health screening or test and health and wellness education. Our Community Needs Assessment has also shown that in our region the following groups are more likely than their counterparts to not access healthcare: women, African-Americans, Hispanics, people younger than 65, those with no high school diploma and people with low income. Furthermore, in calendar year 2011, according to Midland Community Healthcare Services (MCHS), 25% of prenatal women presented to their clinics for the first time in the 2nd trimester and 3% presented for the first time in their 3rd trimester.

- **Rationale:**

  Our most recent Community Needs Assessment has identified that our region, as compared to the state of Texas and the United States, has a higher percentage of adults who do not access most of the basic aspects of preventive care such as screenings and routine lab work due to lack of education and cost barriers. Patients, especially those that can be categorized as “at risk,” need access to preventative care in order to avoid and/or track the onset of chronic diseases, which will ultimately lead to better patient outcomes and fewer preventable hospital admissions down the line. The continually increasing number of uninsured and underinsured patients presenting to our ED for primary care or potentially preventable diseases has created a financial burden on the hospital district, in addition to resulting in suboptimal patient outcomes.

- **Related Category 3 Outcome Measure(s):**

  Through the direct outreach to the disparity groups identified as at-risk in our community needs assessment (low income females of childbearing age), we will be able to educate the targeted population on how to better care for themselves and their families and how to access basic healthcare services in the most appropriate way based on their needs. This will in turn reduce the inappropriate usage of our ED by this specific demographic and allow them to get primary care earlier on, improving the outcomes of their pregnancies and lessening the financial burden on the state and the hospital district. This will be accomplished through strategically incentivizing this population and streamlining their access to the preventative screenings and care they need.

- **Relationship to other Projects**

  This project will use the resources of 68 NURSE (1.6.2) and the MCHS prenatal access project (1.1.1) as part of the educational material provided to these groups.

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

- **Plan for Learning Collaborative:**
  RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

- **Project Valuation:**

  The valuation of each MMH project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Patients, especially those that can be categorized as "at risk," need access to preventative care in order to avoid and/or track the onset of chronic diseases, which will ultimately lead to better patient outcomes and fewer preventable hospital admissions down the line. The continually increasing number of uninsured and underinsured patients presenting to our ED for primary care or potentially preventable diseases has created a financial burden on the hospital district, in addition to resulting in suboptimal patient outcomes. Focusing on this population will help MMH produce a more valuable use of time and funds for the benefit realized to the target population.

136143806.2.4	***2.6***	***2.6.1***	***Implement Evidence-based Health Promotion and Disease Prevention Programs***
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.12***	***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-3. Implement, document and test an evidence-based innovative project for targeted population. By the end of DY2, we will have relocated and reestablished a more effective Hope Chest program to incentivize women in their early trimester to engage in prenatal care, through a partnership with the local March of Dimes office. Metric P-3.1. Document implementation strategy and testing outcomes. Data Source Performing Provider contract or other documentation of implementation by Performing Provider Milestone 1 Estimated Incentive Payment: $975,994	Milestone 2 I-8. Increase access to health promotion programs and activities using innovative project option. By the end of DY3, we will have increased the number of people in the targeted population by 10% over the number calculated for DY2 receiving at least one intervention (free screening/tests/ vaccinations) consistent with the evidence-based model showing that individuals who receive regular health screenings are more proactive in their healthcare and more likely to self-manage their diseases. Estimated potential reached in DY2 based on DY1 data in selected demographic is 100 people. Metric I-8.1.a&b. # of individuals receiving at least one intervention in target population # of individuals in target population Data Source I-8.1.c. Documentation of target population reached, as designated in the project.	Milestone 3 I-8. Increase access to health promotion programs and activities using innovative project option By the end of DY4, we will have increased the number of people in the targeted population by 20% over the number calculated for DY3 receiving at least one intervention (free screening/tests/ vaccinations) consistent with the evidence-based model showing that individuals who receive regular health screenings are more proactive in their healthcare and more likely to self-manage their diseases. Metric I-8.1.a&b. # of individuals receiving at least one interventions in target population # of individuals in target population Data Source I-8.1.c. Documentation of target population reached, as designated in the project. Milestone 3 Estimated Incentive Payment: $783,092	Milestone 4 I-8. Increase access to health promotion programs and activities using innovation project option By the end of DY5, we will have expanded our existing community health events to include at least 2 additional secondary and tertiary service areas where need has been determined based on market share, demographic and geographic specific data as collected through hospital and community clinic software programs. Metric I-8.1.a&b. # of individuals in target population reached by the innovative project # of individuals in target population Data Source I-8.1.c. Documentation of target population reached, as designated in the project. Milestone 4 Estimated Incentive Payment: $619,045

136143806.2.4	***2.6***	***2.6.1***	***Implement Evidence-based Health Promotion and Disease Prevention Programs***
Midland Memorial Hospital			***136143806***
Related Category 3 Outcome Measure(s):	***136143806.3.12***	***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 Estimated Incentive Payment: $998,210		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $975,994	Year 3 Estimated Milestone Bundle Amount: $998,210	Year 4 Estimated Milestone Bundle Amount: $783,092	Year 5 Estimated Milestone Bundle Amount: $619,045
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,376,341			

Identifying Project and Provider Information:
DIABETES COORDINATED CARE (DCC) Center-PERMIAN BASIN
2.2 Expand Chronic Care Management Models/081939301.2.1
Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:

Provider: Texas Tech University Health Sciences Center of the Permian Basin is comprised of 50 providers and has clinics located in Ector County (approx. 900 square miles with a population of approx. 100,000), Midland County (approx. 900 square miles with a population of approx. 100,000) and Ward County (approx. 835 square miles with a population of approx. 7,000). In 2011 the population of RHP 14 was reported at 398,463 and is anticipated to increase to 424,968 by 2030. RHP 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. During FY11 TTUHSC provided services to 21,397 patients through 58,620 patient visits. In FY12 TTUHSC Permian Basin saw a total of about 2,700 diabetic patients with 61% of those being Medicare, Medicaid and unfunded. Approximately 900 of those patients were seen in Family Medicine. In DY2 TTUHSC is going to start a patient database that will identify diabetic patients that will be seen under the Chronic Care Model. By the end of DY 4 we expect to have an estimated 1,000 patients in the database and being seen under the Chronic Care Model. By the end of DY5 we hope to increase that number to 1,200.

Intervention: Diabetes is a chronic disease and should be managed by implementing the six components documented in the Wagner's chronic care model. In the TTUHSC Odessa Family Medicine clinics diabetes care is similar to most other clinics in the USA which is uncoordinated, sporadic and reactive interventions. This type of care for diabetes usually fails to provide the outcomes we want to achieve. We propose to change and enhance the process of taking care of patients with diabetes through implementing a Diabetes Medical Home based on the components of the Wagner's chronic care model.

Need for this project: Odessa Texas has a high prevalence rate of patient with diabetes and a high rate of underinsured and uninsured patients. Most patients diagnosed with diabetes in the hospital are unable to get access to a diabetes medical home due to their insurance status and are lost to follow up until they show up in the emergency room with complications. This causes a financial burden not only for the county but also on the family particularly if the patient is working or taking care of the family. Ector County does have a community health clinic where patients with diabetes are taken care of in the conventional model but unable to provide a comprehensive chronic care. We propose to provide a diabetic medical home for all those who are unable to follow up due to the above mentioned barriers. The diabetic medical home will be based on the chronic care model

Target population: We have already made advances in implementing part of the chronic care model. This includes the implementation of the electronic medical record last year and building a diabetes registry. We already have a faculty and nurse designated to lead the process of change. We are still in the process in implementing the coordination of consults for several associated morbidity that patients with diabetes have. Feedbacks from consultants are sporadic and we are not sure if patients have completed the consults. In the new model we will be able to coordinate consults more efficiently and can prevent complications that are commonly seen. At present there is hardly any feedback to providers on how they are doing with patient outcome which is an essential component of the chronic care model.

TTUHSC clinics in the Odessa/Midland area have a greater share of uninsured, Medicaid and Medicare patients. They also have a greater share of medically vulnerable patients with financial challenges. Many of the private healthcare providers do not accept uninsured and Medicaid patients causing long delays in receiving care and obtaining appointments if they are accepted as patients. Care for patients with diabetes is complex and requires service not only from the primary care provider but also from diabetes educators, podiatrists, ophthalmologists, cardiologists, nephrologists, vascular surgeons and wound care providers.

Category 1 or 2 expected patient benefits:

1. Change process for taking care of patients with diabetes based on the chronic care model
2. Capture uninsured and underinsured patients discharged from hospital
3. Decrease emergency visits for diabetes complications.

Category 3 Outcomes:

Improve 10% from baseline the proportion of patients that are at goal for Hemoglobin A1c, LDL and Blood pressure. Increase 10% from baseline the rates for yearly micro albumin, eye exam, and feet exam.

Project Description:

Care of diabetes in Odessa/Midland area and the RHP 14 region has been uncoordinated and unmonitored to date. This is especially true for the vulnerable population who are at the highest risk for poor outcomes. Diabetes is a chronic disease and the Wagner's chronic care model has been shown to improve diabetes care outcomes. Our project will include a Diabetes Coordinating Center (DCC) clinic that will coordinate all aspects of diabetes care based on the Wagner's Chronic Care Model. Our goal is establishment of a medical home where care for patients with diabetes is coordinated through a multidisciplinary collaborative high performance team based on the Wagner's chronic care model, thereby transforming the process of delivering healthcare and ultimate improvement of the health status of patients with diabetes, while decreasing emergency room (ER) visits at Medical Center Hospital, thus reducing healthcare costs and ER utilizations.

Patients with diabetes are cared for by multiple providers utilizing individual practice styles and without composite knowledge of the outcomes of their care. A significant number of patients who are uninsured or underinsured use the ED for sporadic healthcare when faced with acute symptoms. Hospitals have started screening for diabetes in all patients seeking care in the ER. Patients lacking adequate health insurance, who are diagnosed with diabetes, are unable to establish healthcare because of barriers in accessing medical care and are thus lost to follow-up. When they return to the ER, their diabetes is out of control and frequently requires hospital admissions for associated preventable complications. Additionally, it is known that uncoordinated care for diabetes increases morbidity and mortality. There is an urgent need for coordination of diabetes care and monitoring of outcomes in the Odessa area.
TTUHSC clinics in the Odessa/Midland area have a greater share of uninsured, Medicaid and Medicare patients. They also have a greater share of medically vulnerable patients with financial challenges. Many of the private healthcare providers do not accept uninsured and Medicaid patients causing long delays in receiving care and obtaining appointments if they are accepted as patients. Care for patients with diabetes is complex and requires service not only from the primary care provider but also from diabetes educators, podiatrists, ophthalmologists, cardiologists, nephrologists, vascular surgeons and wound care providers.

Our goal is to create a coordinated care center that will implement the core components of the chronic care model. The center will attend patients with diabetes and coordinate their care including all educational aspects of nutrition and self-management. The Diabetes Care Center at TTUHSC, which is accessible to all patients regardless of financial status, will be promoted in the community. Establishment of the DCC Center will enable us to implement a centralized, flexible, integrated, outpatient, coordinated diabetes care for all patients in all TTUHSC Family Medicine (FM) outpatient clinics in the Permian Basin thus reducing ED utilization by patients with the diagnosis of diabetes.

Starting Point/Baseline Data:

Staff for the multi-disciplinary teams will be hired and trained to utilize the Chronic Care Model for Diabetes in both the third and fourth years of the project. The goal is to be determined as to how many patients will receive care under the Chronic Care Mode for Diabetes in the fourth and fifth year of the project. It is expected that by the fourth year of the project, 50% of patients enrolled in the project would have one self-management goal. Additionally there should be a significant decrease in ER visits.

In FY12 TTUHSC Permian Basin saw a total of about 2,700 diabetic patients with 61% of those being Medicare, Medicaid and unfunded. In DY2 TTUHSC is going to start a patient database that will identify diabetic patients that will be seen under the Chronic Care Model. By the end of DY 4 we expect to have an estimated 1,000 patients in the database and being seen under the Chronic Care Model. By the end of DY5 we hope to increase that number to 1,200.

Rationale:

Although the community needs assessment identifies 10% of Texans as diabetic other data suggests this number could be as high as 34%. The age adjusted mortality rate from diabetes in 2009 was 23.1 per 100,000 persons among the population of RHP 14 counties (same for Texas-23.1) and from heart disease was 205.7 (Texas-186.7). Diabetes contributes to a large

proportion of the heart disease and is likely associated with the increased mortality rate from heart disease in RHP 14 counties. Diabetes is a chronic disease with multiple associated diseases such as obesity, hypertension, hyperlipidemia, kidney failure, coronary artery atherosclerosis, peripheral vascular disease, lower extremity amputation and blindness. The cost for Texas to care for chronic diseases will reach $187 billion in 2013, which includes cost of treatment and loss in productivity. Despite the dire consequence and cost of a complex chronic disease like diabetes, the care for patients with diabetes is fragmented, sporadic and uncoordinated. The situation of diabetes care is further challenging when the population face barriers such as low income low level education, inability to communicate in English, belonging to a minority group, under-insured and un-insured and limited access to healthcare. In the RHP 14 counties, 18% live in poverty, 26% did not graduate from high school, 13% spoke English less than "very well", 42% were Hispanic (2011), 29% were un-insured, 30% had Medicaid/Medicare/CHIP and 42% had commercial insurance (2011). Direct patient care physicians rate in RHP 14 is 137.3 (rate per 100,000 population) and for Texas it is 165.

Unique community need identification number the project addresses:

- CN-1: High rate of chronic disease
- CN-5: Low utilization of preventative care services

Related Category 3 Outcome Measure(s):

- IT-1.11 Diabetes Care: BP Control (<140/80mm Hg) (stand-alone measure)
    - At the present, 34% of Texans have diabetes. The age adjusted mortality rate from diabetes in 2009 was 23.1 per 100,000 persons among the population of RHP 14 counties (same for Texas-23.1) and from heart disease was 205.7 (Texas-186.7). Diabetes contributes to a large proportion of the heart disease and is likely associated with the increased mortality rate from heart disease in RHP 14 counties.
    - Diabetes encompasses several complications that increase morbidity, mortality and cost. In the diabetic population mortality and morbidity rates are higher from cardiovascular disease, lower limb amputations, blindness and chronic kidney disease. Diabetes has reached an epidemic proportion particularly in the Hispanic and African American population. RHP 14 has a large Hispanic community and many of them are lacking health insurance and do not have a diabetic home.
    - Patients without a diabetic home use the ER disproportionately and thus strain the community health care resources. Milestones and metrics for diabetes care have been well established and improvement in these measures has proven to

decrease diabetes related mortality and morbidity rates as well as ED utilization while providing care to the vulnerable population.

Relationship to other Projects:

This project supports and reinforces several other projects within the RHP 14 Plan listed below.

- V.I.P. Relationships in the Patient Home (1.1.2)
- New Model of Diabetes Care in the Out Patient Clinic (2.3.1)
- Continuity of Care from the Hospital to the Out Patient Setting (2.12.2)

Relationship to Other Performing Providers' Projects in the RHP:

TTUHSC will partner with the community hospital (Medical Center Hospital) in Odessa. Faculty members have been working with the diabetes education team and ICU team in standardizing and implementing diabetes care. Several of our faculty members are members of the hospital advisory board on diabetes care. Our project will work closely with MCH hospitalists and ED physicians for following patients that do not have a medical home.

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.2.1	**2.2 EXPAND CHRONIC CARE MANAGEMENT MODEL**	**2.2.1 REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES**	**DIABETES COORDINATED CARE (DCC) CENTER-TTUHSC-PERMIAN BASIN**	
Texas Tech University Health Sciences Center of the Permian Basin				*081939301*
Related Category 3 Outcome Measure(s):	081939301.3.7	**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-3*]: Develop a comprehensive care management plan Metric 1 [*P-3.1*]: Documentation of care management plan Data Source: Program materials Milestone 1 Estimated Incentive Payment *(maximum amount):* $167,887 **Milestone 2** [P-9]: Develop program to identify and manage chronic care patients needing further clinic intervention Metric 1 [P-9.1] increase the number of patients identified as needing screening tests , preventative tests and/or clinical services Data Source: patient database Milestone 2 estimated incentive payment: $167,887 **Milestone 3** [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the	**Milestone 5** [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1 [P-4.1]: create 1 new team Data Source: HR documents showing completion Milestone 5 Estimated Incentive Payment: $245,814 **Milestone 6** [P-2]: Train assigned multi-disciplinary 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 multi-disciplinary team staff trained by 75% Data Source: HR Training documents Milestone 6 Estimated Incentive Payment: $245,814		**Milestone 8** I-18] Improve the percentage of enrolled patients with self-management goals Metric 1 [I-18.1]]: Enrolled patients with self-management goals Goal: Have at least 50% of enrolled patients with 1 self-management goal Data Source: Patient Registry Milestone 8 estimated incentive payment:$197,223 **Milestone 9** [I-17]Apply the Chronic Care Model to Chronic Diabetes Clinics Metric 1[I-17.1] Increase number of patients receive care under the Chronic Care Model for diabetes Baseline/goal: To see an estimated 1,000 patients under the new model who will be listed on the patient registry Data Source: Patient registry Milestone 9 estimated incentive	**Milestone 12** [I-17]Apply the Chronic Care Model to Chronic Diabetes Clinics Metric 1[I-17.1] Increase number of patients receive care under the Chronic Care Model for diabetes Baseline/goal: To see an estimated 1,200 patients under the new model who will be listed on the patient registry Data Source: Patient registry Milestone 12 estimated incentive payment:$254,071 **Milestone 13** [P-16] Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-16.1]: Participate in semiannual meetings Data Source: Meeting notes Milestone 13 estimated incentive

081939301.2.1	**2.2 EXPAND CHRONIC CARE MANAGEMENT MODEL**	**2.2.1 REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES**	**DIABETES COORDINATED CARE (DCC) CENTER-TTUHSC-PERMIAN BASIN**	
Texas Tech University Health Sciences Center of the Permian Basin				*081939301*
Related Category 3 Outcome Measure(s):	081939301.3.7	**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)**
Wagner Chronic Care Model or similar Metric 3: [P-4.1] Show plan of formalized team structure and start recruiting staffing Data Source: HR Documents showing recruiting Milestone 3 estimated incentive payment: $167,887 **Milestone 4**[P-X] Establish base line rates Metric 1[P-X.1]: Use newly created patient registry to establish baseline rates, starting from zero. This is a brand new patient registry. Data Source: Patient registry Milestone 4 estimated incentive payment: $167,887	**Milestone 7** [P-13] Develop and implement program for diabetes care managers to support primary care clinics Metric 1 [P-13.1] Clinics organized and plan developed for structure implementation Data Source: plan documentation Metric 2[P-13.1] Implement program to start seeing patients under new model of care Data Source: documentation showing implementation of program Milestone 7 estimated incentive payment:$ 245,815		payment: $197,223 **Milestone 10** [P-16] Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-16.1]: Participate in semiannual meetings Data Source: Meeting notes Milestone 10 estimated incentive payment:$ 197,223 **Milestone 11** [P-X]: Assess efficacy of processes in place and recommend process improvements to implement, if any Metric 1:[P-X.1]: Identifying opportunities, if any, to improve on the project Baseline/goal: Evaluate the chronic care model of delivery and determine what improvements can be done, if any	payment: :$254,071 **Milestone 14** [P-X]: Assess efficacy of processes in place and recommend process improvements to implement, if any Metric 1:[P-X.1]: Identifying opportunities, if any, to improve on the project Baseline/goal: Evaluate the chronic care model of delivery and determine what improvements can be done, if any, and look into possible expansion of project into Midland Data source: Evaluation reports Milestone 14: Estimated incentive payment:$254,072

081939301.2.1	**2.2 EXPAND CHRONIC CARE MANAGEMENT MODEL**	**2.2.1 REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES**	**DIABETES COORDINATED CARE (DCC) CENTER-TTUHSC-PERMIAN BASIN**	
Texas Tech University Health Sciences Center of the Permian Basin				*081939301*
Related Category 3 Outcome Measure(s):	081939301.3.7	**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)**
			Data source: Evaluation reports Milestone 11: Estimated incentive payment:$ 197,223	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $671,548	Year 3 Estimated Milestone Bundle Amount: $737,443		Year 4 Estimated Milestone Bundle Amount: $788,892	Year 5 Estimated Milestone Bundle Amount: $762,214

081939301.2.1	**2.2 EXPAND CHRONIC CARE MANAGEMENT MODEL**	**2.2.1 REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES**	**DIABETES COORDINATED CARE (DCC) CENTER-TTUHSC-PERMIAN BASIN**	
Texas Tech University Health Sciences Center of the Permian Basin				*081939301*
Related Category 3 Outcome Measure(s):	081939301.3.7	**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)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,960,097				

Identifying Project and Provider Information:
NEW MODEL FOR DELIVERY OF DIABETES CARE IN THE OUTPATIENT CLINIC: 081939301-2.2
2.3 Redesign Primary Care
Project Option 2.3.1, Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:
Provider:

- Texas Tech University Health Sciences Center of the Permian Basin is comprised of 50 providers and has clinics located in Ector County (approx. 900 square miles with a population of approx. 100,000), Midland County (approx. 900 square miles with a population of approx. 100,000) and Ward County (approx. 835 square miles with a population of approx. 7,000). In 2011 the population of RHP 14 was reported at 398,463 and is anticipated to increase to 424,968 by 2030. RHP 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. During FY11 TTUHSC provided services to 21,397 patients through 58,620 patient visits.

Intervention(s):

- This project will establish clinics focused on management of diabetes, blood pressure and lipids to meet the goals of the ADA and AHA.
  a. Implement Tier 1 Stations clinics to care for diabetic patients without cardiovascular complications. The goal is prevention of diabetic complications including heart attack, stroke and nerve damage.
  b. Implement Tier 2 Stations clinics to care for diabetic patients with advanced diabetes and diabetic complications. The goal is prevention/delay of diabetic complications including heart attack, stroke, amputations and blindness.
  c. Develop a Diabetes Registry for documenting health outcomes, demonstrating efficacy of the Stations model for delivery of health care and developing a data base so patients can easily participate in clinical trials .

Need for the Project:

- The goal is prevention and delay of diabetic complications and reduced hospital readmissions for an increasing number of people. By necessity, a system must be in place to provide out-patient primary care and guarantee continuity of care after hospital discharge.
  - This goal reflects the regional goal to decrease high rates of chronic disease as well as reduce the high costs associated with preventable hospitalization admissions and readmissions.

- In FY12 approximately 2,700 diabetic patients were seen with 61% of them being on Medicare, Medicaid or unfunded. There were approximately 10,000 visits in FY12. By

redesigning the clinic TTUHSC expects to increase the number of patient visits by 15% over baseline in DY4 and by 25% over baseline in DY5.

Target Population:

- Ethnic groups at high risk for diabetes, hypertension and stroke include Hispanic (47%), African American (11%), Asian (4%) and American Indian (3%). Approximately 50% of the high-risk population is Medicaid eligible or indigent.

Expected Outcomes:

- 10% reduction in A1C
- Control of blood pressure and cholesterol in >50% of patients

>80% with HEDIS markers for diabetes care (eye exams, foot exams, immunizations, etc)

Project Description:

There are 23 million people in the United States who have diabetes. Another 50 million have pre-diabetes and will develop type 2 diabetes. Diabetes and its associated conditions and complications consume almost 1/3 of the national health care budget. Few patients are managed to the standards of the American Diabetes Association (ADA), the American Association of Clinical Endocrinologists (AACE) or the American Dietetic Association. Currently only 36% of patients with T2D are at glycemic goal and less than 10% are managed to contemporary goals for blood pressure, lipids and glucose. Challenges include inadequate blood pressure control, rare complete physical examinations, failure to perform routine eye examinations and deficient monitoring of A1C, lipids and urinary proteins. This is especially of concern because multiple studies over the past 30 years have documented that micro-vascular disease can be prevented or delayed by controlling blood glucose. Further, macro-vascular disease can be decreased by controlling blood pressure, lipids and glucose (ADVANCE, ACCORD VADT and ORIGIN trials). The Government Commission, as of July 2012 called for new approaches to address diabetes health care. The Commission placed emphasis on prevention, delay of diabetes and education on the patient's responsibility for the management of their own health.

The traditional physician-patient clinic visit is not time-efficient. Diabetes care simply does not fit into the model of addressing a "Chief Complaint." A time-analysis of the diabetes visit in our academic setting revealed that an average of 25-35 minutes was needed to meet the standards of care recommended by the ADA or AACE. This is an unacceptable approach to meeting the challenge of the diabetes epidemic. Our proposal focuses on the implementation of a new and transformed model for structuring the diabetes clinic visit, reaching out to the community with education initiatives on prevention or delay of diabetes, and on delivering comprehensive longitudinal care in a time-efficient, cost-contained format. The intent is to "raise the floor" on treating diabetic patients.

Project Specifics:

- Develop staffing and implementation plan to accomplish goals and objectives by redesign of diabetic patient care

- Develop program to identify and manage chronic care patients needing further clinical intervention
- Improve the percentage of patients in RHP 14 receiving standardized care according to the approved clinic protocols and care redesign
- Develop and implement program to assist patient to better manage chronic conditions
- Increase the number of patients in case management registry
- Improve the percentage of patients with self-management goals

Starting Point/Baseline Data:

Currently, we have established diabetes clinics at TTUHSC-PB in the Department of Internal Medicine and the Department of Family Practice where many patients with type 2 disease are seen. After restructuring clinic logistics, we plan to amalgamate these entities into a 2-tiered system for patients with early and late disease. In brief, the new model for care will be based on the standard of care and on the designing of a new clinic model in West Texas. We have demonstrated that use of the new clinic model would allow us to increase the number of patients seen, a 10% improvement in A1C control achieved and blood pressure and lipids managed to goal.

In FY12 approximately 2,700 diabetic patients were seen with 61% of them being on Medicare, Medicaid or unfunded. There were approximately 10,000 visits in FY12. By redesigning the clinic TTUHSC expects to increase the number of patient visits by 15% over baseline in DY4 and by 25% over baseline in DY5.

Rationale:

Of the patients seen in Midland-Odessa, approximately 50% are non-European Caucasian. Diabetes, hyperglycemia or pre-diabetes is approximately 50% greater in the Hispanic and African-American groups. However, the incidence of abnormal fuel metabolism is so great in all groups that a new model for delivering diabetes care is needed. Although our programs at the university, the hospital and the community are high quality, problems remain for optimizing care. Specifically, our major focus in this proposal is the redesign of the out-patient clinic visit.

Community Need Addressed:

- CN-1: High rates of chronic disease
- CN-2: High costs associated with preventable hospitalization admissions and re-admissions

Project Goals:

1. A two-tiered system for diabetes care will be established based on the “Stations” model

described below. Tier 1 (seen in Family Medicine) will focus on patients with pre-diabetes and diabetes that can be managed with oral agents. Tier 2 (seen in Internal Medicine) will focus on patients with more advanced or uncontrolled diabetes requiring insulin therapy, patients with severe end-organ complications, and those with type 1 diabetes. The time analysis of the Stations model demonstrated a 2-fold increase in the number of patients seen and approximately a 1% improvement in average A1C over the traditional physician-centered encounter. Care will be provided in the departments of Internal Medicine and Family Practice and coordinated by a joint faculty led by the Division of Endocrinology in the Department of Internal Medicine. A registry will be implemented and interfaced with data acquisition for tracking improvements in diabetes care and monitoring longitudinal standards per the ADA and Texas Diabetes Council (TDC) recommendations. To meet the nationally accepted marker for ophthalmologic/optometric care we propose implementation of automated retinal photography and will subscribe to the Wilmer Institute (Johns Hopkins) for web-based interpretations. This approach to eye care has been successfully used in clinics at University of North Texas Health Science Center in Fort Worth, TX.

2. The structure of Tier 1 and Tier 2 diabetes stations will be the same. Specifics for the stations include:

   - **Reminder phone calls** will be made the day before the scheduled visit. Phone calls reduce the "no-show" rate about 20%.

   - **"The Bag"** is essential. All patients receive an official canvas bag at the initial visit. The bag has several compartments and contains basic literature about diabetes and nutrition, a glucose log book, and a pen. At every return visit, the patient ***must bring the bag*** with all medications, over-the-counter products, dietary supplements, written glucose records and questions (English or Spanish), previous instructions, and their glucose meter. Written records are necessary because the date and time are rarely set correctly in the glucometer memory. Further, the bag helps formalize the patient's approach to managing their diabetes.

   - **"The Ready Room"** is where patients will go before they are seen by the physician, PA or NP. The medical assistant records vital signs and checks the patient's A1C.

   - **"The Exam Room**" is where shoes and socks are removed, medications lined up on the counter, and requests for refills noted. The Certified Nursing Assistant (CNA) uses a patient care flow sheet to update health maintenance items such as immunizations, eye exams, mammograms, and laboratory results. CNA's are indispensable and will be empowered to address deficiencies in health care

maintenance. Generating flow sheets requires effort, but are well worth it because health care maintenance is complete before the doctor enters the room. The physician encounter focuses on the medical issues. Decisions regarding blood pressure and lipid control usually require little time. However, titrating diabetes medications requires reviewing the patient's glucose records together with laboratory data and discussion of results. To optimize this aspect of management, written glucose records must be in a "time sensitive" format for fast analysis. The physician then generates a therapeutic plan. Braddock et al. analyzed 1,057 audio taped clinic encounters and found that only 0.5% of the clinical decisions were effectively communicated to the patient. Specific and complete instructions need to be written.

- **Training Room"** will be used for the CNA to conduct a short review session emphasizing prevention of hypoglycemia, maintenance of glucose records, and using medications as directed. CNA's also teach the use of the glucometer, insulin pens, etc.

- "**Check-out**" will allow the receptionist to initiate check-out procedures and rescheduling by reviewing the patient instructions using verbal repetition of the written materials. Rehearsal is important because approximately 60% of adults in West Texas are functionally illiterate.

3. Prevention and delay of diabetes will be approached with an additional instrument beyond discovering at-risk persons visiting the emergency department or at hospital admission. More important than medications is the patient's participation in the management of their health and learning to take responsibility. To facilitate this we will introduce an "out-person" or Promotores (community health workers). This program will be implemented and patterned after the model developed for the Federally-sponsored DREAMS Project. DREAMS focused on prevention and delay of diabetes in the Hispanic area of north Fort Worth, TX where one Promotore was assigned to work with 5 families. They teach a culturally relevant, language appropriate curriculum, focusing on basic concepts of nutrition, weight loss and prevention of diabetes. The program in Fort Worth was successful and at-risk persons and undiagnosed diabetes was discovered in 50% of the Hispanic fathers by tracking anthropometric data on elementary school children in the Fort Worth ISD back to the nuclear family. Training of Promotores is planned to begin this year at the MCH Diabetes Center and will utilize the Fort Worth curriculum.

Expected Outcomes:

- Based on our experience we expect to:
    - Increase the number of patients seen for diabetes care compared to our current system
    - Decrease average A1C by 1% (i.e. meet ADA goals for health-status based glycemic goals)
    - Increase control of patients for blood pressure and lipids
    - Meet HEDIS markers for eye and foot examinations.
- We expect to fully implement the Stations model in the diabetes clinics in the departments of Internal Medicine and Family Practice to provide quality health care as defined by the ADA and demonstrate cost-avoidance as measured by decreased end-organ diabetic complications and hospital re-admissions. This goal reflects the regional goal to decrease high rates of chronic disease as well as reduce the high costs associated with preventable hospitalization admissions and readmissions.
- In conjunction with the MCH Diabetes Center we expect to provide an effective Promotores program for community outreach and education to prevent or delay pre-diabetes from progressing to type 2 diabetes.

Related Category 3 Outcome Measure(s):

- IT-1.10 Diabetes care: HbA1c poor control (>9.0%) (Stand-along measure)
- The Department of Internal Medicine provides care to a significant number of underinsured and uninsured patients within RHP 14. This population of patients, often times do not have access to quality medical care. The community delivers health care to an increasing number of people with limited budget resources. The University is a state entity caring for many Medicaid and Medicare recipients and MCH is the tertiary county hospital with emphasis on caring for these people. Our proposal targets management of at-risk persons and people with diabetes to prevent the progression of pre-diabetes, delay end-organ complications of diabetes and reduce hospital re-admissions.

Relationship to other Projects:

This project supports and reinforces several other projects within the RHP 14 Plan listed below.

- Family Medicine Rural Track Permian Basin (Category 1.2.4)
- Diabetes Coordinated Care Center (Category 2.2.1)

This proposal defines the goals and logistics for providing health care after the transition from in-patient to out-patient status. This project is directly related to our other proposal that creates the link to capture patients discharged from the hospital and address prevention/delay and management of diabetes. The rationale is based on evidence that diabetes can be prevented if risk factors are recognized early and life-style changes made and that diabetic complications can be prevented or delayed with proper care. Key to realizing these goals are the establishment of mechanisms to allow collaboration between the various providers and development of efficient clinics to guarantee continuity of care.

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301-2.2	***2.3***	***2.3.1***	***NEW MODEL FOR DELIVERY OF DIABETES CARE IN THE OUTPATIENT CLINIC***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.8*	*IT 1.10*	*Diabetes Care:HbA1C poor 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-4]: Implement patient visit redesign in primary care clinics Metric 1 [P-4.1]: Completion of all four phases of the redesign project; (1) establish method to collect and report cycle time at least monthly; (2) compare cycle time to other potential measures of efficiency; (3) map patient visits from beginning to end to determine how time in the clinic is spent and to identify any bottlenecks in the visit process; and (4) conduct a series of tests on the visit model, debrief thoroughly, and refine the model Baseline/goal: Develop a 2 tier system for patients to be seen by determining severity of diabetes. Designing the stations model in the clinics. Data source: Documentation showing station model and program implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $160,712 **Milestone 2** [P-X]: Designate/hire	**Milestone 4** [P-5]: Train staff on methods for redesigning clinics to improve efficiency Metric 1:[P-5.1]: Increase number of staff trained on stations model Baseline/goal: To train all staff assigned to stations model clinic Data source: Training documentation Milestone 4 estimated incentive payment:$132,362 **Milestone 5** [P-X]: Establish baseline rates Metric 1:[P-X.1]: Establish baseline rates upon which improvements will be measured Data source: Patient registry and IDX Milestone 5 estimated incentive payment: $132,362 **Milestone 6** [P-X]: Pilot a new process or program Metric 1: Implement stations model		**Milestone 8** [P-X]: Assess efficacy or processes in place and recommend process improvements to implement, if any Metric 1 [P-X.1]: Review stations model and determine if any improvements are needed or necessary Baseline/goal: To continuously improve the process and patient care Data source: Documentation showing review Milestone 8 estimated incentive payment:$283,192 **Milestone 9**[I-18] Increase capacity to redesign primary care Metric 1[I-18.3] Increase number of primary care visits by 15% over baseline Date source: patient registry Milestone 9 estimated incentive payments:$283,192	**Milestone 10** [P-X]: Assess efficacy or processes in place and recommend process improvements to implement, if any Metric 1 [P-X.1]: Review stations model and determine if any improvements are needed or necessary Baseline/goal: To continuously improve the process and patient care, look into expansion of program into Midland Data source: Documentation showing review Milestone 10 estimated incentive payment:$273,615 **Milestone 11**[I-18] Increase capacity to redesign primary care Metric 1[I-18.3] Increase number of primary care visits by 25% over baseline Date source: patient registry baseline Milestone 11 estimated incentive

081939301-2.2	***2.3***	***2.3.1***	***NEW MODEL FOR DELIVERY OF DIABETES CARE IN THE OUTPATIENT CLINIC***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.8*	*IT 1.10*	*Diabetes Care:HbA1C poor 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)**
personnel or teams to support and/or manage the project Metric 1 [P-X.1]: designate eight (8) certified nursing assistants and/or additional staff to work in new clinic model Data Source: Documentation showing work assignment Milestone 2 estimated incentive payment:$ $160,712 **Milestone 3**[P-X]: Implement, adopt, upgrade, or improve technology to support the project Metric 1: [P-X.1]: Upgrade technology needed to support new stations model. Baseline/goal: To acquire additional medical/computer equipment to improve patient care Data source: purchasing documentation Milestone 3 estimated incentive payment:$ $160,713	in diabetes clinics Baseline/goal: To implement stations care model in clinics Data source: Documentation showing plan implementation Milestone 6 estimated incentive payment:$ 132,361 **Milestone 7** [P-12] Participate in face to face learning at least twice a year with other providers and the RHP to promote collaborative learning around shard or similar projects Metric 1 [P-12.1]: Participate in semi-annual meetings with other providers and the RHP to share lessons learned and gain knowledge Data source: Documentation of Meetings Milestone 7 estimated incentive payment:$ 132,361			payments:$273,616

081939301-2.2	***2.3***	***2.3.1***	***NEW MODEL FOR DELIVERY OF DIABETES CARE IN THE OUTPATIENT CLINIC***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.8*	*IT 1.10*	*Diabetes Care:HbA1C poor 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $482,137	Year 3 Estimated Milestone Bundle Amount: $529,446		Year 4 Estimated Milestone Bundle Amount: $566,384	Year 5 Estimated Milestone Bundle Amount: $547,231
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,125,198				

Identifying Project and Provider Information:
CONTINUITY OF CARE FROM THE HOSPITAL TO THE OUTPATIENT SETTING: 081939301.2.3
2.12 Implement /Expand Care Transitions Programs
Project Option 2.12.2, Texas Tech University Health Sciences Center (TTUHSC)/081939301

Summary Information:
Provider:

- Texas Tech University Health Sciences Center of the Permian Basin is comprised of 50 providers and has clinics located in Ector County (approx. 900 square miles with a population of approx. 100,000), Midland County (approx. 900 square miles with a population of approx. 100,000) and Ward County (approx. 835 square miles with a population of approx. 7,000). In 2011 the population of RHP 14 was reported at 398,463 and is anticipated to increase to 424,968 by 2030. RHP 14 is made up of 16 counties, in which all but 2 are considered rural and 10 are frontier counties. During FY11 TTUHSC provided services to 21,397 patients through 58,620 patient visits.

Intervention(s):

- Identify all patients seen at MCH who have diabetes or undiagnosed diabetes or pre-diabetes
- Establish transition protocol so that patients with abnormal glucose have appropriate and timely follow-up
- Institute a tracking system to facilitate patient adherence with follow-up continuity of care
- Develop data base, in collaboration with Texas Tech University, to demonstrate outcomes and logistical benefits of the transition program

Need for the Project:

- Many patients present to the hospital with diabetic complications and many of these patients are frequently re-admitted to the hospital for the same problems. One major reason for re-admission is lack of continuity of care. Where does the patient go after discharge?
- Texas Tech University Health Sciences Center in collaboration with Medical Center Hospital has developed this project to focus on continuity of care into the clinic after hospital discharge. The goal is to reduce hospital re-admissions and to focus on prevention/delay of diabetic complications when follow-up care in the clinic is facilitated.

Target Population:

- Ethnic groups at high risk for diabetes, hypertension and stroke include Hispanic (47%), African American (11%), Asian (4%) and American Indian (3%). Approximately 50% of the high-risk population is Medicaid eligible or indigent.

Expected Outcomes:

- 15% reduction in diabetes 30 day re-admission rate
- 20% increase in patients following up with clinic appointments after discharge
- 20% increase in patient participation with continuity-of-care in the out-patient clinics
- In DY 3 we will be implementing a patient registry in order to track patients and their transition of care from the hospital to the outpatient setting. By the end of DY3 we are estimating that we will have 100 patients listed in the patient registry. By the end of DY4 we estimate that we will increase that number 10% and by 20% at the end of DY5. These patients will be tracked and their outpatient care will be monitored by the case manager. We hope that at the end of DY4 10% of those 100 patients are receiving care under the transition plan on a continuous basis and by the end of DY5 it will have increase by 20% (over baseline). If patients are receiving care in the outpatient setting and being monitored the hospital readmission rate for diabetes should decrease.

Project Description:

Approximately 30% of people admitted to the hospital have diabetes and another 30% have either undiagnosed diabetes or pre-diabetes. Further, those with undiagnosed diabetes have almost a 50% higher mortality rate than those with known diabetes because they have not received interventions as outpatients for control of blood pressure, lipids and glucose. Those with pre-diabetes are not treated or educated about the progression to diabetes and thus usually go on to develop the disease. A stunning report from the Mayo Clinic in Arizona, caring for populations similar to those in West Texas, highlights the problems from admission to discharge. It was discovered that of the patients in local Arizona hospitals diagnosed with diabetes, daily progress mentioned diabetes in only 62% of cases and 60% of discharge summaries. While bedside glucose measurements were ordered on about 80% of cases, the values were tracked only about 50% of the time and only one-third of patients had their therapy changed despite 70% with uncontrolled glucose>200 mg/dL. Further, only 20% of discharges indicated a plan for diabetes follow-up.

In-patient control of hyperglycemia is excellent in the critical care units at Medical Center Hospital (MCH) in Odessa, Texas. Control of diabetes (known and newly discovered) on the general medical floors is good and has been recognized by JAHCO as meeting the new ADA standards of care. However, at discharge follow-up care becomes fragmented and readmissions are common.

Transformational approaches to diabetes care upon hospital discharge are paramount. Specifically, this project will focus on strategies and logistics for capturing patients discharged from the hospital with the goal of providing referral and follow-up care resources to prevent readmissions. This proposal is based on the new US Government Commission statement of

July, 2012 calling for public-private mechanisms to slow, prevent and delay the burgeoning epidemic of diabetes.

Project Goals:

- Implement standardized care transition processes
- Document all patients with abnormal glucose discharged from Medical Center Hospital
- Develop staffing and implementation plan to accomplish goals and objectives of the care transitions program
- Implement standardized care transition processes
- Implement and increase the number of patients in the case management registry
- Improve the percentage of patients in RHP 14 receiving standardized care according to the approved clinic protocols and care transition policies
- Decrease of Diabetes readmissions in RHP 14

Starting Point/Baseline Data:

A program has evolved that now includes a diabetes clinic at TTUHSC-PB, recruitment of four endocrinologists, and Endocrinology Fellowship program to begin July 2013, an in—patient hospital diabetes service, a dedicated Diabetes Center supported by MCH serving Midland-Odessa, and expanding programs at Midland Memorial Hospital (MMH).

Hospital in-patients with diabetes or newly discovered hyperglycemia are seen by the healthcare extenders and the endocrinologist each day. The service provides: 1) patient education or, 2) full management of diabetes or 3) Endocrine/diabetes consultation by the endocrinologist. The Diabetes Center, supported by MCH, has been recognized by the American Diabetes Association and serves as a referral site for all physicians in the community. The center handles adult and pediatric types 1 and 2 diabetes, gestational diabetes care, and all insulin delivery and monitoring devices. Further, MCH has developed outreach programs including community diabetes discussion/lecture groups, weekend programs, screening fairs, home visitations, cooking classes and camps for children. The outreach into the surrounding communities focuses on our Certified Diabetes Educators providing education for school nurses in all the rural independent school districts.

The out-patient diabetes clinics at TTUHSC-PB are located in the Departments of Family Practice and Internal Medicine. In DY 3 we will be implementing a patient registry in order to track patients and their transition of care from the hospital to the outpatient setting. By the end of DY3 we are estimating that we will have 100 patients listed in the patient registry. By the end of DY4 we estimate that we will increase that number 10% and by 20% at the end of DY5. These patients will be tracked and their outpatient care will be monitored by the case manager. We hope that at the end of DY4 10% of those 100 patients are receiving care under the transition plan on a continuous basis and by the end of DY5 it will have increase by 20% (over baseline). If patients are receiving care in the outpatient setting and being monitored the hospital readmission rate for diabetes should decrease.

Rationale:

Of the patients seen in Midland-Odessa, approximately 50% are non-European Caucasian. Diabetes, hyperglycemia and pre-diabetes are approximately 50% greater in Hispanic and African-American groups. However, the incidence of abnormal fuel metabolism is so great in all groups that a new model for delivering diabetes care is needed. Although the programs at TTUHSC-PB, MCH and in the community are high quality, problems remain for optimizing care. Specifically, the next major focus must be on developing mechanisms to bring the programs together for comprehensive health care delivery.

Unique community need identification numbers the project addresses:

- CN-1: High rates of chronic disease
- CN-2: High costs associated with preventable hospitalization
- CN-6: Need to overcome patient access to care barriers

Related Category 3 Outcome Measure(s):

- IT-3.3 Diabetes 30 day readmission rate (Stand-alone measure)
- Transformational approaches to diabetes care upon hospital discharge are paramount. Specifically, this project will focus on strategies and logistics for capturing patients discharged from the hospital with the goal of providing referral and follow-up care resources to prevent readmissions. This proposal of continuity of care from hospital discharge to longitudinal diabetes management for pre-diabetes and type 2 diabetes is the critical bridge linking MCH diabetic care to the out-patient clinics. The benefits of in-patient management of diabetes in the ICU and on the general medical and surgical floors are nullified if patients are lost to follow-up. Further, there is little data supporting high quality in-patient care if mechanisms are not developed to guarantee out-patient continuity. Thus, this “bridge” proposal sets the stage for the out-patient care proposal submitted by the TTUHSC faculty focusing on diabetes management, reductions in hospital readmissions and outcome tracking to demonstrate a successful approach to decreasing the diabetes epidemic.
- The community delivers health care to an increasing number of people with limited budget resources. TTUHSC is a state entity caring for Medicare, Medicaid, Chip and Self-pay patients. MCH is the tertiary county hospital with an emphasis on caring for this population of patients. Thus, the project outlined here specifically targets management of at-risk persons and people with diabetes to prevent the progression of pre-diabetes and reduce hospital readmissions.

Relationship to other Projects:
This project supports and reinforces projects within the RHP 14 Plan listed below:

a. Diabetes Coordinated Care Center (Category 2.2.2)

b. New Model for Delivery of Diabetes care in the out-patient setting. (Category 2.2.1)

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.2.3	***2.12 IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM***	***2.12.2***	***CONTINUITY OF CARE FROM THE HOSPITAL TO THE OUTPATIENT SETTING***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.9*	*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-9*]: Implement a case management registry Metric 1 [*P-9.1*]: Develop/implement a case management registry to capture patients Baseline/Goal: plan for registry Data Source: Document showing plan registry Milestone 1 Estimated Incentive Payment *(maximum amount):* $163,582 **Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1[P-7.1] Documentation of staffing plan Data source: Document the staffing and implementation plan Baseline/goal: Hire/assign 1 data management and hire/assign 1 IT person Data source: HR documentation	**Milestone 3** [P-12]:Participate in face-to-face learning at least twice per year Metric 1[P-12.1} Participation in semi-annual face-to face meetings Baseline/goal: TTUHSC will participate in semi-annual meetings Data source: meeting documentation Milestone 3 estimated incentive payment;$179,634 **Milestone 4**[P-9]: Implement a case management registry Metric 1[P-9.1]: Documentation of registry Baseline/goal: Collect data on referrals for follow-up care and enroll 100 patients in registry Data Source: EMR Milestone 4 estimated incentive payment:$179,633		**Milestone 5**[I-13]: Increase the percent of patients in the case management related registry Metric 1 [I-13.1]: Increase % of patients in the case management related registry Goal: Increase by 10% over baseline Data Source: patient registry Milestone 5 Estimated Incentive Payment: $192,166 **Milestone 6** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transition policies Metric 1 [I-11.1]:Number of patients over time who are receiving care under transition plan Goal: Increase by 10% over baseline Data Source: patient registry Milestone 6 Estimated Incentive Payment: $192,166	**Milestone 7**[I-13]: Increase the percent of patients in the case management related registry Metric 1 [I-13.1]: Increase % of patients in the case management related registry Goal: Increase by 20% over baseline Data Source: patient registry Milestone 7 Estimated Incentive Payment: $123,778 **Milestone 8** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transition policies Metric 1 [I-11.1]:Number of patients over time who are receiving care under transition plan Goal: Increase by 20% over baseline Data Source: patient registry Milestone 8 Estimated Incentive Payment: $123,778 **Milestone 9** [P-12]: Participation in

081939301.2.3	***2.12 IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM***	***2.12.2***	***CONTINUITY OF CARE FROM THE HOSPITAL TO THE OUTPATIENT SETTING***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.9*	*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 2 estimated incentive payment:$163,583				face to face learning (i.e meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiative that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1:</u> [P-12.1] Participate in semi-annual face to face meetings or seminars organized by the RHP Baseline/goal: To attend semiannual meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 9 estimated incentive payment: $123,779

081939301.2.3	***2.12 IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM***	***2.12.2***	***CONTINUITY OF CARE FROM THE HOSPITAL TO THE OUTPATIENT SETTING***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.9*	*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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $327,165	Year 3 Estimated Milestone Bundle Amount: $359,267		Year 4 Estimated Milestone Bundle Amount: $384,332	Year 5 Estimated Milestone Bundle Amount: $371,335
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,442,099				

Identifying Project and Provider Information:
IDENTIFICATION AND INTERVENTION TO ADDRESS LOCAL GAPS IN WOMEN'S HEALTHCARE THROUGH EDUCATION: 081939301.2.4
2.6 Implement Evidence-Based Health Promotion Programs
Project Option 2.6.2, Texas Tech University Health Sciences Center (TTUHSC) 081939301

Summary Information:

- **Provider:** Texas Tech University Health Sciences Center at the Permian Basin (TTUHSC-PB) is a regional campus of Texas Tech University Health Sciences Center. TTUHSC-PB serves a broad geographic population within RHP 14. During FY 2011 TTUHSC provided services to 21,397 patients through 58,620 patient visits.

- **Intervention(s):** Improve patient outcomes in women's healthcare through:
    - Case coordination and patient-centered health education targeting key factors such as patient compliance and navigation through the health system. This intervention will remove barriers to care due to language, literacy, transportation and financial status
    - Educational component at the graduate and undergraduate level training medical students and residents as well as faculty in patient advocacy and cultural awareness. This will improve physician's ability to facilitate primary disease prevention through screening. It will also equip physicians with knowledge and communications skills needed to prevent ongoing disability, hospitalizations and overutilization of emergency services.
    - Health promotion within the community targeting school districts and interdisciplinary work with local universities and colleges (e.g. nursing and social work programs). This intervention will make the community an active participant in improving health indices in the region
    - Health promotion using a multimedia approach. This leg of the project uses social network site such as Facebook and Twitter to educate the community about available services for women at TTUHSC-PB. There will also be web-based interactive learning for patients already receiving care in our institution. Patients may take "courses" related women's health, adolescent sexual health and puberty which encourage screening and health behaviors. Finally, the IT portion of the educational project will provide a means of communication between patient and provider, overcoming geographic barriers, reducing the need for emergent care and increasing patient participation in treatment plans

- **Need for the project:** There are currently no case coordination efforts for Obstetrics and Gynecology or primary care at TTUHSC-PB. This lack of health care education leads to poor patient outcomes including:
    - High rates of chronic disease such as Obesity and smoking related illness which have devastating effects on pregnancy and women's health
    - Low utilization of preventative care services which leads to disability and more costly treatment of later stage disease

- Need for improvement in adolescent health emphasizing healthy choices with regard to sexual risk
- High rate of teen pregnancy: 60% higher in the region compared to the state average.
- Lack of multimedia approach to patient and community education in a significantly rural area where it could close information gaps

- **Target population:** Region 14 women, adolescents and girls who currently have inadequate access to health care information. The project also targets students of both sexes in regional school districts, colleges and universities though education programs on sex education and healthful life choices. . TTUHSC-PB provides care for a significant number of under-insured or un-insured patients within RHP 14. 70% of patients are Medicaid, Medicare-eligible or self-pay. The project will target these populations on site in the clinics though case coordination which educates directs community members to needed services. This coordination process increases not only their access to needed services, but their self-efficacy in obtaining medical care and the follow though required to improve overall health. The project will also target providers, improving their ability to respond to patient's needs-heightening patient-centered care.

- **Category 1 or 2 expected patient benefits:**
  - Obtain information needed for project design and implementation though milestone one: conducting an assessment of health promotion programs that involve community health workers at local and regional level
  - Increase access to health promotion programs and activities using innovative project option
  - increase percentage of target population receiving health promotion education
  - increase percentage of target population accessing health care as a result of improvised awareness
  - Decreases in barriers to healthcare access due to lack of knowledge
  - Improved provider –patient partnership in health promotion

- **Category 3 Outcomes:**

  - Increased USPSTF- endorsed screening for breast and cervical cancers and STDs.
  - Reduced teen pregnancy
  - Education and case coordination will increases in patient centered care and patient advocacy as well as enhance the patient /provider relationship. These interventions will thereby positively impact goals targeting improvement in women's health indices.
  - Patient participation in care plans increases trust, knowledge for both provider ant patient and promotes adherence to treatment regimens.

Project Description:

According to the Community Needs Assessment, more than a quarter of Texas women remain uninsured making access to basic obstetric and gynecologic services such as prenatal care, family planning, annual PAP and disease screening difficult and out of reach for many women. Texas Tech University Health Sciences Center-Permian Basin (TTUHSC-PB), Department of Obstetrics and Gynecology plans to identify barriers of access to women's healthcare locally and in the region to help promote healthy lifestyles and increase preventative care. Key challenges to the Department of Obstetrics and Gynecology is the lack of information. Gaps in access to healthcare in the region have led to known problems for West Texas women; however the magnitude and sources of the problem of access must be established through data gathering in order to effectively put into practice interventions. Once gaps in care are identified TTUHSC will use evidence –based methodologies including social media to help overcome these barriers and increase patient care.

Health education and case coordination improve patient outcomes and healthcare experiences. Health education and case work are an integral part of Comprehensive prenatal care which is known to improve perinatal outcomes and reduce Neonatal Intensive Care stays as well as neonatal morbidity arising from prematurity. By making patients education more accessible TTUHSC hopes to improve the completeness and therefore quality of care given. As a result of this intervention more patients will have healthier behaviors such as starting prenatal care early and avoiding risk of sexually transmitted infections. When healthcare is a priority more preventative medicine is practiced thus reducing healthcare costs. The project will address the challenges noted by producing a women's health education program, offering individual education with outpatient visits to increase compliance, patient ability to participate in care and improve patient community programs such as the ongoing collaborative effort between TTUHSC-PB Department of Obstetrics and Gynecology and the Ector County Independent School District. Health education office will research and create new and innovative ways to make patient education material accessible to all patients focusing on the under/uninsured. The educational component of the project will use social network site such as Facebook and Twitter to educate the community about available services for women at TTUHSC-PB. There will also be web-based interactive learning for patients already receiving care in our institution. Case coordination will also be a part of the patient experience, providing assistance with referrals for insurance coverage, referral to specialty care and provision of social assistance thereby reducing barriers to care.

Project Specifics:

- Expand and improve the existing women's healthcare within our academic medical system and RHP 14 through educational interventions at the graduate and postgraduate levels
- Expand and improve women's healthcare in RFP 14 through health promotion within the community, focusing on health education and case coordination to improve patient outcomes
- Collaboration with local and regional agencies such as school districts, colleges and county health department

- Hire additional staff for the purpose of program development, case coordination and data analysis
- Develop evidence based projects for targeted population, based on distilling the needs assessment and determine priority of interventions for the community

Starting Point/Baseline Data

At present, there are no women's case coordination services at TTUHSC-PB for Obstetrics and Gynecology or Primary Care. TTUHSC-PB Department of Obstetrics and Gynecology does participate in a coordinated school-based reproductive education program in collaboration with other community groups, serving 3000 secondary level students in Ector County Independent School District. There is a need to expand this service into the primary levels within the school system; however there is insufficient manpower for such expansion. Additionally community health assessment data and outcomes data for women's healthcare is limited in the region. There is no web-based health instruction for women's health.

Rationale:

Lack of access to women's healthcare leads to poor pregnancy outcomes, higher teen pregnancy rates, higher STD rates, and decreased access to basic gynecologic services such as cervical cancer screenings and breast cancer screenings. This decreases the quality of life for women and prolongs disability related to gynecologic conditions with a resulting loss of productivity. The project will provide data useful for strategic planning to improve access to care. Defining the magnitude of the problem of access to women's healthcare, using an evidence based process will be a new initiative for TTUHSC-PB Department of Obstetrics and Gynecology.

Community health assessments emanating from this project would provide necessary evidence for intervention/program planning. Faculty and residents at TTUHSC need training on effective methods of acting as patient advocates to complete the patient experience improvement process. Manpower focused on training activities within the academic setting would guarantee a sustained and measurable effort in this area.

Unique Community Need Identification numbers the project address:

- CN-1: High rates of chronic disease
- CN-5: Low utilization of preventative care services
- CN-9: Need for improvement in adolescent health
- CN-11: High rate of teen pregnancy

Related Category 3 Outcome Measure(s):

- IT-12.1 Breast Cancer Screening (Non-standalone measure)

- IT-12.2 Cervical Cancer Screening (Non-standalone measure)
- IT-12.5 Other USPSTF-endorsed screening outcome measure-Sexually Transmitted diseases
- TTUHSC-PB Department of Obstetrics and Gynecology provides care for a significant number of under-insured and un-insured patients within RHP 14. 70% of their patients have either Medicare or Medicaid or are self-pay. This population of patients, often times, does not have access to quality medical care. This plan will work to identify the barriers and gaps in women's healthcare and implement evidence based solutions and education to improve healthcare for women in RHP 14.

Relationship to other Projects:

This project supports and reinforces several other projects within the RHP 14 Plan listed below.

e. Increase Infrastructure Dedicated to Healthcare for Women (Category 1.1.1)

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.2.4	***2.6***	***2.6.1***	***IDENTIFICATION AND INTERVENTION TO ADDRESS LOCAL REGIONAL GAPS IN WOMEN'S HEALTHCARE THROUGH EDUCATION***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.10* *081939301.3.11* *081939301.3.12*	*IT 12.1* *IT 12.2* *IT 12.5*	*Breast Cancer Screening* *Cervical Cancer Screening* *Reported STDs*	
Year 2 (10/1/2012 – 9/30/2013)	**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 assessment of health promotion programs that involve community health workers at local and regional level Metric 1 [*P-1.1]* document regional assessment Baseline/Goal: gather data to identify barriers to access Data Source: data gathered Milestone 1 Estimated Incentive Payment *(maximum amount):* $91,836 **Milestone 2**[*P-X*]: Hire data analysis staff Metric 1 [*P-X.1*]: hire data analysis staff Baseline/Goal: hire 1 data analysis staff Data Source: HR documentation	**Milestone 4**[P-X]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned Metric 1 [P-X.1]: Creation and implementation of community health care office Baseline/goal: creation of community health care office in order to better serve community health needs Metric 2[P-X.2] Identify staffing needs Baseline/goal: To determine staffing needs of office and hire if necessary Data source: office organizational chart Milestone 4 Estimated Incentive Payment *(maximum amount):* $100,846 **Milestone 5**[*P-2]* Development of evidence based projects for targeted population based on distilling the		**Milestone 7** [P-5]: Execution of evaluation process for project innovation Metric 1 [P-5.1]: document evaluative process, tools and analytics Goal: continuous growth and improvement of education programs, continuous improvement and monitoring what works Data Source: documentation of evaluation process Milestone 7 Estimated Incentive Payment: $161,824 **Milestone 8**[I-8]: Increase access to health promotion programs and activities using innovative project option Metric 1 [P-I-8.1]: increase percentage of target population reached	**Milestone 9**[I-8]: Increase access to health promotion programs and activities using innovative project option Metric 1 [P-I-8.1]: increase percentage of target population reached Goal: increase percent of population reached by 7% over baseline Data Source: documentation of population reached Milestone 9 estimated incentive payment:$312,703

081939301.2.4	***2.6***	***2.6.1***	***IDENTIFICATION AND INTERVENTION TO ADDRESS LOCAL REGIONAL GAPS IN WOMEN'S HEALTHCARE THROUGH EDUCATION***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.10* *081939301.3.11* *081939301.3.12*	*IT 12.1* *IT 12.2* *IT 12.5*	*Breast Cancer Screening* *Cervical Cancer Screening* *Reported STDs*	
Year 2 (10/1/2012 – 9/30/2013)	**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: $91,836 **Milestone 3** [P-X]: Complete a planning process/ submit a plan, in order to do appropriate planning for the implementation of a major infrastructure development Metric 1 [P-X.1]: complete a planning process to establish a Community Health Education office Baseline/goal: Creation of Community Health Education Office Data source: complete plan Metric 2 [P-X.1]: recruit and hire a Community Health Education office director Baseline/goal: Creation of Community Health Education Office Data source: HR documentation Milestone 3 estimated incentive payment: $91,835	needs assessment and determine priority of interventions for the community Metric 1 [*P-2.1]* Document innovational strategy and plan for creating and tracking Facebook account/twitter account/other applicable social media Baseline/Goal: create innovational strategy plan Data Source: Innovational plan Milestone 5 Estimated Incentive Payment *(maximum amount):* $100,847 **Milestone 6** [P-3]: Implement, document, and test an evidence based innovative project for target population Metric 1 [P-3.1]: document implementation strategy and testing outcomes		Goal: increase percent of population reached by 5% over baseline Data Source: documentation of population reached Milestone 8 estimated incentive payment:$161,824	

081939301.2.4	***2.6***	***2.6.1***	***IDENTIFICATION AND INTERVENTION TO ADDRESS LOCAL REGIONAL GAPS IN WOMEN'S HEALTHCARE THROUGH EDUCATION***	
Texas Tech University Health Sciences Center				*081939301*
Related Category 3 Outcome Measure(s):	*081939301.3.10* *081939301.3.11* *081939301.3.12*	*IT 12.1* *IT 12.2* *IT 12.5*	*Breast Cancer Screening* *Cervical Cancer Screening* *Reported STDs*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Baseline/Goal: To implement and test patient response of social media education and text messaging Data Source: Documentation of implementation and tracking of patient hits Milestone 6 estimated incentive payment:$ 100,847			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $275,507	Year 3 Estimated Milestone Bundle Amount: $302,540		Year 4 Estimated Milestone Bundle Amount: $323,648	Year 5 Estimated Milestone Bundle Amount: $312,703
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,214,398				

Identifying Project and Provider Information:
Project Title: Patient Centered Medical Home Implementation, 2.1.4 - readiness preparations and establishment of a medical home to more appropriately deliver primary health care to the residents of Culberson County.
Unique Project ID: 176354201.2.1
Performing Provider Name/TPI: Culberson Hospital / 176354201

Project Description:

- Provider: Culberson Hospital is a 14-bed Critical Access Hospital (CAH) located in Van Horn serving the 3,813 square mile area of Culberson County with a population of approximately 2,400.
- Intervention(s): The PCMH project in Culberson County will be based on emphasizing the central importance of primary health care and the promotion of more patient-centered care based on:
    - Convenience
    - Continuity
    - Coordination
    - Comprehensive Care
    - Culture
- Need for the project: Primary and preventative care can be provided in a far less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care.
- Target population: Culberson has a high number of dual eligible Medicare and Medicaid patients and an ever-growing number of aging persons. County data also reveals that Culberson has a higher Hispanic population percentage as compared to the state as a whole. The United States Department of Health and Human Services cites cultural barriers and a lack of access to preventive care as characteristics shaping Hispanic health. These hurdles have lead to higher rates of uninsured, obese and diabetics within the county. Culberson Hospital currently operates a Rural Health Clinic with a yearly encounter rate of approximately 5,500 per year. All patients would be eligible for inclusion in this project.
- Category 1 or 2 expected patient benefits: The PCMH brings care and treatment to a level of proactive response in promoting higher standards of community health through preventative care. Creation of the PCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider
- Category 3 outcomes: IT-9.2 The goal in PCMH development is a multi-year transformational effort as an innovative way to deliver care. By providing the right care

at the right time and in the right setting, over time, patients in Culberson County will hopefully see their overall health improve, and cut costly ED visits 10% by DY5.

Culberson Hospital proposes to transform the Rural Health Clinic currently operated alongside the hospital to a Patient-Centered Medical Home (PCMH) promoting a patient-centered care focus on community wellness and enhanced coordination of care.

The proposed Patient-Centered Medical Home (PCMH) clinic model for Culberson County will be based on emphasizing the central importance of primary health care. As a 'home base,' patients of all ages will have direct access to a personal health care provider. A primary care provider's direct and trusted rapport with patients, paired with a depth and breadth of clinical training across body systems, uniquely positions them to assess an individual's health needs and to tailor an individualized care plan. This relationship is intended to promote provider directed medical practice and ultimately enhance access to care, assure quality and safety and promote comprehensive care coordination.

Emergency Department (ED) utilization has continued to rise across the nation and especially in rural areas. Culberson has experienced the same increase. In the past year alone, hospital ER visits have risen 12.3%. High ED utilization is a considerable concern as it correlates to the increasing cost of health care. Frequent and inappropriate use of hospital EDs is extremely costly. Primary and preventative care through the PCMH can be provided in a far less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. Culberson Hospital views the decreasing of unnecessary emergency room visits through the implementation of the PCMH as an innovative approach to community education and access to information, reduce healthcare costs and tackle health disparities in the county.

The following are primary goals of expanding and enhancing clinical care delivery to the underserved and undereducated Culberson population will be provided through:

Convenience - The PCMH is an accessible point of entry into the health care system each time new care is needed.

- Simplified appointment scheduling
- Reduced wait times
- Expanded hours
- Acceptable opportunities for patients to communicate with personal physician and office staff

Continuity - Each patient has an ongoing relationship with a personal provider.

- Each patient has an identifiable primary care clinician for ongoing care
- Patient is able to make appointments with that particular clinician
- Discussion about PCMH role and expectations with the patient
- Discussion between personal physician and patient on the roles and expectations for the medical home
- Person-focused (not just disease specific) care over time.

- Registry of patients into the PCMH database
- Complete medical records are retrievable and accessible

Coordination – Care plan arrangement alternatives across all domains of the health care system.

- Synchronize care patients receive from other providers (e.g. specialists, hospitals, home health agencies)
- Referral tracking and follow up

Comprehensive Care – A medical home for all stages of life from preventive services to end-of-life care.

- Planned visits
- Patient registry enabling searches for particular conditions and characteristics
- Range of services offered
- Physician directed practice with a team that taking collective responsibility for ongoing patient care

Culture – Implementation and staff education on systems creating an environment focused on quality and safety

- Decision making guided by evidence-based medicine and decision-support tools
- Quality improvement efforts
- Patients participate in decision-making
- Patient feedback is sought to ensure expectations are met

Under this model, patients not only develop a direct relationship with their primary care provider, but also are backed by a clinical care team who service the individualized needs of each patient. This team might include physicians, midlevel providers, pharmacists, nurses, medical assistants, volunteer patient advocates, educators, and personal care coordinators. As a small rural practice, the ultimate goal will be building an integrated team through networking and linking patients to providers and services in surrounding communities. A PCMH will essentially act as the hub of a comprehensive care network accountable for meeting the large majority of each patient's physical needs.

Starting Point/Baseline Data (if applicable)

As a PCMH does not currently exist in Culberson County, implementation of a medical home is an ambitious undertaking that will require the reengineering and redesign of the existing primary clinic operated by the hospital. This practice-altering evolution will including new scheduling and access arrangement, new coordination planning, group visits, new ways to improve quality care, development of team-based care, multiple uses of healthcare information systems and training to assist providers educate their patients about the need for PCMH and the healthcare transformation process.

Rationale:

Culberson Hospital currently operates a Rural Health Clinic with a yearly encounter rate of approximately 5,500 per year. Within this patient pool, Culberson has a high number of dual eligible Medicare and Medicaid patients and an ever growing number of aging persons. 15.1% of the county population is above the age of 65. This statistic is clearly above the 10.5% state average. County data also reveal that Culberson has a higher Hispanic population percentage as compared to the state as a whole. The 74.7% of the population in Culberson from Hispanic or Latino origin is also far above the 38.1% standard set by the state (U.S. Census Bureau, 2011). The United States Department of Health and Human Services cites cultural barriers and a lack of access to preventive care as characteristics shaping Hispanic health. These hurdles have led to higher rates of uninsured, obese and diabetics within the county.

The primary goals to promote more patient-centered care focus on community wellness and enhanced coordination of care. In addition, the PCMH model is viewed as a foundation for the ability to accept the impending alternative payment models under payment reform. PCMH development is a multi-year transformational effort an innovative way to deliver care. By providing the right care at the right time and in the right setting, over time, patients in Culberson County will hopefully see their overall health improve, rely less on costly ED visits and incur fewer avoidable hospital stays.

Unique community need identification numbers the project addresses:

- CN.5 - Low utilization of preventative care services, especially by those with lower incomes.

- CN.2 - High costs associated with preventable hospitalization admissions and readmissions.

Related Category 3 Outcome Measure(s):

OD-9 Right Care Right Setting: IT-9.2 ED appropriate utilization – Reduce overall visits by 10% over established DY3 baseline by end of DY5

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. Although major evaluations of the PCMH are only now getting off the ground, there is an ever-growing body of data supported by research organizations spanning privately insured patients, Medicaid, SCHIP and Medicare beneficiaries, and the uninsured. The findings of these studies are starting to emerge in peer-reviewed journals and other publications demonstrating that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care.

Across diverse settings and patient populations, evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield an excellent return on investment in:

- Quality of care - patient experiences and satisfaction, care coordination, and access are demonstrably better.

- Strengthened primary care - within a relatively short time, reductions in emergency department visits and inpatient hospitalizations are realized producing savings in total costs. These savings at a minimum offset the new investments in primary care. In many cases initial investments appear to produce a reduction in total costs per patient.

Relationship to other Projects
N/A

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

Plan for Learning Collaborative:
RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. The collaborative would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation
The PCMH brings care and treatment to a level of proactive response in promoting higher standards of community health through preventative care. Without the proper continuum of care, the Culberson population often arrives at the ER for treatment. The creation of the PCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider.

Culberson Hospital used a basic valuation tool to measure the efficacy of potential project. The tool was centered on the following questions:

- Does the project meet the waiver goals?

- Does the project address a pressing community need?

- Which population is being served?

- What is the project investment (Resources needed)?

After receiving input from outside consultation and visiting with local stakeholders, the PCMH Project was deemed to be a top priority in strengthening the health delivery system of Culberson County.

Milestones and Metrics Table

Unique Identifier: 176354201.2.1	***2.1.4 – Implement other evidenced based project to develop or enhance PCMH Model***	***Readiness preparations and establishment of a medical home to more appropriately deliver primary health care to the residents of Culberson County.***		
Performing Provider Name: Culberson Hospital		***TPI: 176354201***		
Related Category 3 Outcome Measure(s):		***176354201.3.1***	***IT-9.2***	***ED Appropriate Utilization***
Year 2	Year 3	Year 4		Year 5
Process Milestone 1: [P-X]: Complete a planning process assessing appropriate steps and barriers in PCMH implementation Metric 1:[P-X.1]: Submission of completed gap analysis and feasibility study Goal: Complete and utilize gap analysis and feasibility studies to determine necessary steps to conversion of existing primary care clinic to PCMH achieving NCQA recognition. Data Source: Completed Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $121,910	Process Milestone 2 [P-8]: Develop or utilize evidence based training materials for medical homes based upon NCQA standards Metric 1 [P-8.1]: Submission of documentation pertaining to obtained staff training materials Goal: Achievement of meaningful and sustainable PCMH transformation requires solid education/training foundation Data Source: Obtained Training Materials Process Milestone 2 Estimated Incentive Payment (maximum amount): $66,498.50 Process Milestone 3 [P-9]: Train existing PCP clinic personnel on PCMH change concepts.	Process Milestone 4 [P-1]: Implement the medical home model in existing primary care clinic Metric 1: [P-1.1]: Increase Number of Primary care clinics using medical home model Data Source: Clinical Documentation Goal: Implement PCMH Process Milestone 4 Estimated Incentive Payment (maximum amount): $66,692 Improvement Milestone 1 [I-15]: Increase number of medical home patients that are able to identify their usual source of care as being managed in medical homes Metric 1 [I-15.1]: PCMH should be seen by the patient as the 'home base' or usual source of care		Improvement Milestone 2 [I-18]: Obtain medical home recognition by a nationally recognized agency Metric 1 [I-18.1]: Medical home recognition/accreditation Goal: Increase overall quality improvement as result of meeting NCQA standards. Data Source: Patient Survey Improvement Milestone 2 Estimated Incentive Payment (maximum amount): $110,187

	Metric 1 [P-9.1]: Number of personnel trained Goal: 100% of personnel trained Data Source: Submission of training records and HR documentation Process Milestone 3 Estimated Incentive Payment (maximum amount): $66,498.50	Goal: Increase number of patients that are able to identify their usual source of care to being managed by a medical home to 50% of total PCMH Data Source: Patient Survey Improvement Milestone 1 Estimated Incentive Payment (maximum amount): $66,692	
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $121,910	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $132,997	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $133,384	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $110,187
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 498,478			

Identifying Information:
Title of Project: Apply process Improvement Methodology to Improve Quality/Efficiency: Implement a Severe Sepsis Resuscitation and Management Bundle
RHP Project Identification Number: 112711003.2.1
Reference Number of Project Option Planning Protocol: 2.8.11
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): ORMC will implement both the Resuscitation and Management Bundles as endorsed by the Institute for Healthcare Improvement.

- Need for the project: Currently ORMC is one of the few hospitals in RHP 14 that have the resources needed for implementing both Sepsis bundles. As the RHP population continues to age, it is expected that the rate of sepsis will increase and more patients will present themselves needing care.

- Target population: ORMC will target patients that present themselves with signs and symptoms of septicemia or develop symptoms once in the hospital. Approximately 35% of the patients ORMC serves are considered indigent or Medicaid and ORMC expects this project to benefit that population.

- Category 1 or 2 expected patient benefits: ORMC will increase complete usage of both bundles along with its timely application to all patients that present themselves to ORMC with Sepsis. ORMC will also look at developing a program to teach outlying facilities what to look for to help identify septic patients.

- Category 3 outcomes: IT-4.8 - Sepsis Mortality - Our goal is to reduce Sepsis Mortality rates through the complete integration of the Sepsis Resuscitation and Management bundles.

Project Description:

Through the development of a comprehensive sepsis management model and implementation of the Sepsis Resuscitation and Management bundle, Odessa Regional Medical Center will have the ability to support the region's population with better overall management of this acute illness.

Project Goal(s) and Relationship to Regional Goals:

Odessa Regional Medical Center will implement a Severe Sepsis Resuscitation and Management intervention bundle that will include early recognition and treatment program of severe sepsis patients called Early Goal Directed Therapy (EGDT). This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl). The program will set necessary reporting requirements that are focused on improved patient outcomes and reduced mortality rates. This data will be shared to the State and participating outlying hospitals and as well as shared benchmarking and learning tools for hospital partners within the community. Due to our high NICU volume, ORMC will also modify both bundles for implementation within our NICU. With 34% of our NICU admissions coming from outside the Midland/Odessa area, proper treatment for Sepsis in infants will have a significant impact for Region 14.

ORMC has set the following goal(s) for the implementation of the sepsis resuscitation and management bundles, including: complete usage of both bundles within the recommended time frame and decrease the sepsis mortality rate. The project will also address the following regional goals:

Additionally, the ORMC Sepsis Management program committee will help draft and enforce strategies for reducing the incidence and prevalence of sepsis in the community throughout the life of the Waiver, in addition to reducing the mortality rate.

Challenges/Issues Faced By Provider:

- Staff training and implementation within key departments of both sepsis bundles and early goal directed therapy compliance.
- Physician support with full-time hospitalist coverage
- Central line placement upon detection of possible sepsis as best practice to implement treatment resuscitation goals within 6 hours.

5-year Expected Outcome:

Implementing this multifaceted bundled approach for severe sepsis resuscitation and management, using of evidence-based interventions (using IHI.org's Sepsis Resuscitation and Sepsis Management Bundles) will improve clinical outcomes for severe sepsis patients in the local and outlying areas, as a result of timely assessment and sepsis treatment. The program is anticipated to reduce the overall mortality rate caused by sepsis, within the region. Based on previous years, ORMC expects to have approximately 200 patients each year with a primary discharge diagnosis of sepsis each year. ORMC will look at improving its use of both the resuscitation and management bundles within the recommended timeframe and successfully perform them on approximately 90% of all patients with sepsis by year 5. This will impact approximately 200 patients a year, with a total patient impact of 660 patients by DY 5.

Starting Point/Baseline:

This is a new project/initiative for the Performing Provider, and will start with the development of a multidisciplinary committee that will have the oversight of the program implementation. Develop and implement the Severe Sepsis Resuscitation and Management intervention protocols.

Rationale:

This project meets CN2 as identified in the RHP14 Community Needs Assessment.

In calendar year 2011, Odessa Regional Medical Center had approximately 60 patients with Sepsis listed as a primary discharge diagnosis, along with 145 patients within its Neonatal Intensive Care Unit. Sepsis can strike anyone at any age; although the very old, very young, hospitalized patients and people with certain chronic medical conditions (pneumonia, trauma, surgery, burns, cancer and AIDS) may be at greater risk. Early detection and evidenced-based management are crucial tools to improve patient outcomes and reduce mortality rates.

According to the Surviving Sepsis Campaign, it is estimated that there are 750,000 episodes of sepsis annually in the United States. Shock develops in approximately 40% of patients with sepsis and is associated with a mortality rate in excess of 40%. Sepsis represents the 10th leading cause of death in the United States and national costs associated with the disease process are estimated to be in the range of 18 billion dollars annually, representing 25% of the total ICU costs. An increase in the rate of Sepsis disease is anticipated due to aging of the population. Elderly patients are more susceptible to sepsis, and are more likely to have underlying co-morbidities and have less physiologic reserve to tolerate the insult, all of which adversely impacts survival. The project will affect outlying counties of West Texas region through ORMC sharing guidelines and education of front line staff in the Emergency Department through early recognition of Systemic Inflammatory Response System (SIRS) criteria. These participating facilities will adopt a proven early recognition protocol for patients that will fall victim to sepsis. This will set the emergency activation of set protocols and guidelines and possible transfer of the patients to major hospital facilities that have Sepsis Management program.

Project Components:

Through the implementation of the sepsis bundles, ORMC will meet the following project components.

a) *Develop multidisciplinary team to oversee and develop policies and procedures for sepsis program*. A group that consists of various disciplines will need to be developed to ensure correct implementation and full compliance with both bundles. All disciplines will need to be on the same page in order to perform bundles within the necessary time frame.

b) *Identify tracking methods to ensure compliance with both sepsis bundles*. A process and procedure will also need to be developed in order to ensure accurate tracking of bundle compliance.

c) *Conduct quality improvement for program through the Plan-Do-Check-Act cycle*. Continuous improvement through the PDCA cycle will help identify and implement improvements within our processes and procedures in order to deliver better care.

Relationship to Other Projects:

The implementation of the Sepsis Resuscitation and Management Bundles will relate to the following projects: implement evidence-based health promotion and disease prevention programs.

This project is related to the following Category 4 Reporting Domains: RD 2 (30 day readmissions) and RD 3 (Potentially Preventable Complications: PPC # 35).

Related Category 3 Outcome:

OD 4: Potentially Preventable Complications and Healthcare Acquired Conditions
IT: Sepsis Mortality *(IT-4.8)*

Relationship to Other providers' projects within the RHP:

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community (especially in the hospital ICU) by addressing prevention of the onset of sepsis and implementing immediate protocols for treating the condition. Sepsis causes severe organ and/or tissue damage, and is often fatal, so it is an imperative reform when considered in light of patient health outcomes and quality/quantity of life. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk for the condition, making it a high value project.

112711003.2.1	***2.8***	***Apply process Improvement Methodology to Improve (2.8.11)***	***Implement a Severe Sepsis Resuscitation and Management Bundle***
Odessa Regional Medical Center		***112711003***	
Category 3 Outcome Measure(s):	***112711003.3.10***	***IT-4.8***	***Decrease Sepsis Mortality Rate***
[redacted]			
Process Milestone1 [P-X]: Development of the Sepsis Resuscitation and Management Bundle policies and procedures, which will include EGDT, and implementation of the Sepsis Resuscitation and Management Bundle in order to set a baseline going forward, and improve the present sepsis rate of mortality, incidence, and prevalence. ***Metric 1 [P-X.1]:*** Number of patients with some component of sepsis bundles performed. ***Data source:*** EHR, claims ***Process Milestone 1 Incentive Payment:*** $496,351 **Process Milestone 2 [P-X]:** Create multidisciplinary Sepsis Management program committee that will target specific workflows and processes for sepsis bundle implementation and Train staff (nurses, MD's and ancillary staff) in process improvement (specifically, on policies and procedures for implementation of Sepsis Bundles).	**Process Milestone 3 [P-X]:** Develop baseline for the use of initial Sepsis Resuscitation and Management Bundle within the recommended time frame (golden hour), as a percentage of complete initial Sepsis Resuscitation and Management Bundles used. This milestone will allow ORMC to determine the successful implementation of the program, and address by modifying the program or performing additional training with the providers. ***Metric 1 [P-X.1]:*** Numerator: Total number of patients with initial sepsis bundles performed within recommended time limit. Denominator: Total number of patients with initial sepsis bundles performed. ***Data source***: EHR ***Process Milestone 3 Incentive Payment:*** $537,227	**Improvement Milestone 1 [I-X]:** Improve the incomplete use of the Sepsis Resuscitation and Management Bundle, as a percentage of total Sepsis Resuscitation and Management Bundles attempted, by 10 % from baseline year. ***Metric 1 [P-X.1]***: Denominator: Total number of patients with incomplete usage of sepsis bundles in DY4. Numerator: Total number of patients with incomplete usage of sepsis bundles in DY3. ***Data source***: EHR ***Improvement Milestone 1 Incentive Payment:*** $533,868 **Improvement Milestone 2 [I-X]:** Use of initial Sepsis Resuscitation and Management Bundle within the recommended time frame (golden hour), as a percentage of complete initial Sepsis Resuscitation and Management Bundles used. Goal to increase by 10% from baseline year 2. This milestone will allow ORMC to determine the successful implementation of the program, and address failures by modifying the	**Improvement Milestone 3 [I-X]:** I-X: Improve the incomplete use of the Sepsis Resuscitation and Management Bundle, as a percentage of total Sepsis Resuscitation and Management Bundles attempted, by 15 % compared to baseline year. ***Metric 1 [I-X.1]***: Denominator: Total number of patients with incomplete usage of sepsis bundles in DY5. Numerator: Total number of patients with incomplete usage of sepsis bundles in DY4. **Data source:** EHR ***Improvement Milestone 3 Incentive Payment:*** $438,199 **Improvement Milestone 4 [I-X]:** Increase use of initial Sepsis Resuscitation and Management Bundle within the recommended time frame (golden hour), by 15% compared to baseline year. ***Metric 1 [I-X.1]:*** Numerator: Total number of patients with initial sepsis bundles performed

Metric 1 [P-X.1]: Number of providers/staff trained Numerator: number of staff trained Denominator: total number of staff ***Data source***: Documentation of in-service, training sessions, staff meetings. ***Process Milestone 2 Incentive Payment:*** $496,351	**Process Milestone 4 [P-X]:** Develop baseline for the incomplete use of the Sepsis Resuscitation and Management Bundle, as a percentage of total Sepsis Resuscitation and Management Bundles attempted. ***Metric 1 [P-X.1]***: Denominator: Total number of patients with incomplete usage of sepsis bundles in DY3. Numerator: Total number of patients with incomplete usage of sepsis bundles in DY2. ***Source:*** EHR ***Process Milestone 4 Incentive Payment:*** $537,226	program or performing additional training with the providers. ***Metric 1 [P-X.1]:*** Numerator: Total number of patients with initial sepsis bundles performed within recommended time limit. Denominator: Total number of patients with initial sepsis bundles performed. *compare this number with DY3 ***Data source***: EHR ***Improvement Milestone 2 Incentive Payment:*** $533,868	within recommended time limit. Denominator: Total number of patients with initial sepsis bundles performed. *compare this number with DY4 ***Data source***: EHR ***Improvement Milestone 4 Incentive Payment:*** $438,199
Year 2 Estimated Milestone Bundle Amount: $992,701	Year 3 Estimated Milestone Bundle Amount: $1,074,453	Year 4 Estimated Milestone Bundle Amount: $1,067,737	Year 5 Estimated Milestone Bundle Amount:$876,399
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$ 4,011,289			

Identifying Information
Title of Project: Expand Chronic Care Management Model for Diabetes care
RHP Project Identification Number: 112711003.2.2
Reference Number of Project Option Planning Protocol: 2.2.2
Performing Provider Name/TPI: Odessa Regional Medical Center, 112711003

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): ORMC will develop and implement an inpatient and outpatient diabetes center that will assist with development and management of this chronic condition. ORMC will establish a team with the focus on developing treatment protocols and plans for patients within the hospital. This team will also work to educate the patient and provide dietary consults for the patient to follow. ORMC will then develop an outpatient program where patients can be provided follow up, attend diabetes classes, and work with providers on their treatment plans.

- Need for the project: According to the community needs assessment, diabetes is the leading driver in costs for the Medicaid population. Development of better management goals and patient compliance will help reduce severe consequences from diabetes and help drive down overall healthcare costs.

- Target population: According the community needs assessment approximately 10% of the Texas population has diabetes. This does not take into consideration those who have gone undiagnosed or have pre-diabetes. With the demographic profile of RHP 14, the diabetes population is believed to be above the Texas average. Approximately 35% of the patient population ORMC serves has Medicaid or is considered indigent. Many of these patients are considered to be high risk for diabetes, mismanaging their diabetes, or going undiagnosed.

- Category 1 or 2 expected patient benefits: Increase the number of encounters by the diabetes clinic in order to better manage their condition through the establishment and compliance of self-management goals.

- Category 3 outcomes: IT-1.10 - Diabetes Care: HbA1c poor control (>9.0%) – This project aims to increase the number of patients with HbA1c level below 9.0%.

Project Description:

Odessa Regional Medical Center will establish a centralized approach to diabetes management based upon proven clinical guidelines and development of an interdisciplinary team. The interdisciplinary team will serve variety of functions that will affect behavior changes toward self- care management of diabetes through patient and community education strategies, referral, support groups, case management and or outreach programs. This will not only improve overall health of diabetic patients but affect prevention and reduction of diabetes related risk factors.

Project Goals and Relationship to Regional Goals:

Patients with chronic conditions receive proactive, ongoing care that keeps patients healthy and empowers patients to self-manage their high-risk conditions in order to reach blood sugar goals and avoid their health from deteriorating and needing ED or inpatient care.

ORMC has set the following goals for its diabetes chronic care management program: increase the amount of encounters by the diabetes program, increase the amount of patient with self-management goals, and better management of patient glucose levels. The program also addresses the following regional needs: diabetes screening and education (CN9), effective outpatient management (CN12), cost effective care (CN13), and enhancing the overall patient experience (CN19).

Challenges/Issues Faced By Provider:

- Identifying Physician champions for establishment of protocols
- Identifying quality insulin management vendor
- Establishing interdisciplinary diabetes team
- Ensuring populations compliance with diabetes treatment plans

5-year Expected Outcome:

To decrease complications related to diabetes due to lack of coordinated care, and an increase in patients knowledge on disease management.

Based on previous years, ORMC expects to have the following impact:

- Year 3: 2,250 patients served with 562 being Medicaid/indigent
- Year 4: 2,587 patients served with 646 being Medicaid/indigent
- Year 5: 3,037 patients served with 759 being Medicaid/indigent
- Total amount of patients served is expected to be approximately 7,874 .

- *ORMC will use DY 3 in order to establish a true baseline that will be used to expand upon during the remaining demonstration years.

Starting Point/Baseline:

Develop a new comprehensive diabetes care management program that can be tracked and managed in a preventive manner. Currently diabetes management is responsibility of the physicians with minimal support.

Rationale:

This project meets CN 1 as identified in the RHP 14 Community Needs Assessment.

Through the development of a comprehensive diabetes chronic care management model, Odessa Regional Medical Center will have the ability to support the regions high-risk diabetes population with better overall management of this chronic condition.

In 2009 the Texas Department of State Health Services reported 38 deaths due to diabetes, a number that is expected to have risen in subsequent years and is higher than the average death rate from diabetes among RHP 14 counties and the statewide rate (23 deaths in 2009). According to the Community Needs Assessment, nearly 10% of all adults in Texas have been diagnosed with diabetes. In addition, Ector County reported being above the national benchmark in several categories, increasing the risk of diabetes within its population, including: 28% of the county population having reported no leisure time physical activity, above the national benchmark of 21% along with 32% of its population being classified as obese.

According the Community Needs Assessment, from 2005-2010, RHP 14 has experienced 3,011 potentially preventable hospitalizations associated with diabetes complications, resulting in approximately $175,064,959 in hospital charges. Due to the current population within RHP 14 affected by diabetes, the region has identified this disease as one of its areas for improvement.

Project Components:

Through the establishment of a diabetes chronic care management program, ORMC will meet the following components:

a) *Develop a multidisciplinary team based on the Wagner Chronic Care Management Model.* Using this model, ORMC will develop a team best suited to assist patients manage their conditions in both an inpatient and outpatient setting.

b) *Implement both an inpatient and outpatient clinic for diabetic patients.* Diabetes is a condition that often leads to complications if left untreated. It can exacerbate another condition or be the main source of issues. With development of the diabetes clinic, ORMC will be able to treat both.

c) *Develop Self-management goals for patients with diabetes.* Treatment goals will serve as a basis for having the patient be active in his/her treatment for their condition. Patient involvement will help support development of goals that are obtainable and ensure compliance with overall treatment.

d) *Continuous Quality Improvement.* ORMC will implement the Plan, Do, Check, and Act model as part of its continuous quality improvement initiative. An analysis of the diabetes program will be conducted and reviewed for improvement opportunities, followed by an action plan and timeline for implementation. After implementation is complete, an assessment of the program will be taken for execution into other service lines if revealed appropriate.

Related Category 3 Outcome Measure:

IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%). Management of one's glucose levels is key to managing diabetes and leading to better health outcomes. In 2009, the American Diabetes Association issued a statement stating, "Lowering A1C to below or around 7% has been shown to reduce micro-vascular and neuropathic complications of type 1 and type 2 diabetes."

Relationship to Other Projects:

The expansion of a chronic care management model will relate to the following projects: increase in specialty care access, implement evidence-based health promotion and disease prevention programs, and expand specialty care capabilities. This program will allow ORMC to assist the RHP population evidenced by better outcome measures associated with Category 4; including: diabetes potentially preventable admissions, diabetes 30-day readmissions, and potentially preventable complications associated with diabetes.

This project will tie to the following Category 4 measures by increasing the effective management of high risk diabetes patients' conditions: RD1 (Potentially Preventable Admissions: Diabetes Admission Rates), RD 2 (30 day readmissions: Diabetes); and RD 4 (Patient centered healthcare: Medication management).

Relationship to other providers' projects in the RHP:

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project meets the goals of the Waiver by increasing preventative care and management to avoid preventable use of the Emergency Department and readmissions for controllable diseases. Valuation for this project also took into consideration statistical figures such as the 3,011 potentially preventable hospitalizations associated with diabetes complications, the 10% of the Texas population already diagnosed with diabetes, and the 500,000 approximated cases of undiagnosed diabetes. There is large percentage of the population at risk for diabetes, as well a solid number of adults already diagnosed. The project will require time, effort, and resources to develop, implement, and maintain over the life of the Waiver.

Milestones and Metrics Table:

112711003.2.2	***2.2***	***Expand Chronic Care Management Model for Diabetes care (2.2.2)***	***Development of diabetes clinic***
Odessa Regional Medical Center			***112711003***
Category 3 Outcome Measure(s):		***112711003.3.11***	***IT-1.10***	***Increase patients with HbA1C < 9.0***
[redacted]			
<u>Process Milestone 1 [P-4]:</u> Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar. ORMC will recruit for development of a multi-disciplinary team, consisting of: physicians, mid-level practitioners, dieticians, licensed clinical social workers, nurses, diabetes educators, and other providers as needed. ***Metric 1 [P-4.1]*:** Increase the number of multi-disciplinary teams. ***Data source*:** documentation of recruitment efforts and formation of team **Process Milestone 1 Incentive Value: $868,613**	**<u>Process Milestone 2 [P-3]:</u>** Develop a comprehensive care management program. ORMC will develop a comprehensive inpatient diabetes care management program for diabetic patients. ***Metric 1 [P-3.1]:*** A documented diabetes care management program that supports the diabetic RHP population. **Projected Impact:** 2,250 total patients with 562 Medicaid/Indigent ***Data source:*** Program materials **Process Milestone 2 Incentive Value: $940,146**	**<u>Improvement Milestone 1 [I-21]:</u>** Improvements in access to care of patients receiving chronic care management services. ORMC will increase the number of patients participating in the comprehensive diabetes care management program over baseline by 15%. ***Metric 1 [I-21.2]:*** Documentation of increased number of unique patients served by care management program: number of patients within diabetes registry. **Projected Impact:** 2,587 total patients with 646 Medicaid/Indigent ***Data source:*** EHR, registry **Improvement Milestone 1 Incentive Value: $467,135** **<u>Improvement Milestone 2 [I-18]:</u>** Increase the percentage of patients with self-management goals over baseline by 15%. ***Metric 1 [I-18.1]:*** Increased number of patients with self management goals. Numerator: The number of patients with	**<u>Improvement Milestone 3 [I-21]:</u>** Improvements in access to care of patients receiving chronic care management services. ORMC will increase the number of patients participating in the comprehensive diabetes care management program over baseline by 20%. ***Metric 1 [I-21.2]:*** Documentation of increased number of unique patients served by care management program: number of patients within diabetes registry. **Projected Impact**: 3,037 total patients with 759 Medicaid/Indigent ***Data source:*** Registry **Improvement Milestone 3 Incentive Value: $383,423** **<u>Improvement Milestone 4 [I-18]:</u>** Increase the percentage of patients with self-management goals over baseline by 20%. ***Metric 1 [I-18.1]:*** Increased number of patients with self management goals.

		diabetes in the registry with at least one recorded self-management goal. Denominator: total number of patients with diabetes in the registry. ***Data source*:** Registry **Improvement Milestone 2 Incentive Value: $467,135**	Numerator: The number of patients with diabetes in the registry with at least one recorded self-management goal. Denominator: total number of patients with diabetes in the registry. ***Data source*:** Registry Improvement **Milestone 4 Incentive Value: $383,424**
Year 2 Estimated Milestone Bundle Amount: $806,569	Year 3 Estimated Milestone Bundle Amount: $872,993	Year 4 Estimated Milestone Bundle Amount: $867,536	Year 5 Estimated Milestone Bundle Amount:$712,074
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $3,259,172			

Identifying Information:
Title of Project: Expand Chronic Care Management Model for Congestive Heart Failure
RHP Project Identification Number: 112711003.2.3
Reference Number of Project Option Planning Protocol: 2.2
Performing Provider Name/TPI: Odessa Regional Medical Center

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): ORMC will develop a program that will identify congestive heart failure ("CHF") patients and work with healthcare providers to develop a treatment plan, based on the stage of their condition. After the plan is developed, ORMC will offer follow-ups and work to ensure compliance with the treatment plan.

- Need for the project: Currently ORMC has no specific treatment program for patients with this condition. Between 2006 and 2010, Ector County had 2,066 potentially preventable hospitalizations due to CHF. With the development of a clinic that will help develop and support treatment plans, ORMC will be able to assist in management of these patients resulting in less hospitalizations.

- Target population: This project will serve patients that present themselves with signs and symptoms of congestive heart failure. Approximately 35% of the patients ORMC serves are considered indigent or Medicaid.

- Category 1 or 2 expected patient benefits: Based on currently available data and our current patient levels, ORMC estimates that the Congestive Heart Failure Clinic will increase its enrollment of patients with a comprehensive set of self-management goals by up to 15% compared to baseline year.

- Category 3 outcomes: IT-3.2 - Congestive Heart Failure 30 Day Readmission Rate - Our goal is to reduce the 30-day CHF readmission rate by DY5 in an amount to be established as part of the initiative.

Project Description:

Odessa Regional Medical Center will develop a Heart Failure/Anticoagulants Clinic (HF/AC) for patients diagnosed with Heart Failure with moderate to high risk features as defined in the inclusion criteria for referral to an outpatient management clinic. The HF/AC clinic will draw and monitor lab work, PT/INR and adjust anticoagulant dosages according to physician protocol. The clinic will work in close contact with referring facilities, as well as monitor readmissions to acute care hospitals.

Project Goals and Relationship to Regional Goals:

Patients with chronic conditions receive proactive, ongoing care that keeps patients healthy and empowers patients to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care.

Heart failure patients will receive early diagnosis and effective treatment that allows a rapid discharge from the Emergency Department or inpatient care (48 hours). This treatment will also decrease potential readmissions to the hospital. The HF/AC Clinic will be used as a specialty clinic that follows up on patient education of treatment and implementation of all self- care independence focused on improving symptoms, decreasing volume overload, and improving perfusion.

ORMC has set the following goals for the CHF Clinic: Increase encounters for the CHF/Anticoagulation clinic, decrease admissions/readmissions of CHF patients, and increase patient compliance through the development of self-management goals. Regionally, the plan addresses the following needs: Effective outpatient management (CN12), cost effective care (CN13), Availability of public health and preventive measures (CN14), and enhancing the overall patient experience (CN19).

Challenges/Issues Faced By Provider:

- Identify resources needed to develop clinic
- Staff training on HF/Anticoagulation protocols
- Physician support
- Patient compliance with treatments

5-year Expected Outcome:

Decrease complications and readmissions related to Heart Failure due to lack of coordinated care, while increasing patient's knowledge on disease management.
Based on previous years, ORMC expects to have the following impact:

- Year 3: 750 patients served with 187 being Medicaid/indigent
- Year 4: 825 patients served with 206 being Medicaid/indigent
- Year 5: 862 patients served with 215 being Medicaid/indigent
- Total amount of patients served is expected to be approximately 1,950.

- *ORMC will use DY 3 in order to establish a true baseline that will be used to expand upon during the remaining demonstration years.

Starting Point/Baseline:

Develop a new comprehensive Heart Failure/Anticoagulant Clinic. Currently Odessa Regional Medical Center is looking to develop a full clinic dedicated to congestive heart failure, including; space identification, staffing, and procedure/policy development, which will take place in DY2.

Rationale:

This project meets CN1 as identified in the RHP 14 Community Needs Assessment.

Through the development of a comprehensive chronic care management clinic for Heart Failure/Anticoagulation, Odessa Regional Medical Center will have the ability to support the region's population with better overall management of this chronic condition.

Heart Failure has resulted in 2,066 potentially preventable hospitalizations in Ector County from 2006-2010. In 2009, heart disease was the number one cause of death (777), well above cancer which was second with 608. Heart Failure is a complex disease and requires intensive, lifelong management of symptoms along with adherence to prescribed treatments.

Patient self-management goals will be picked as a target to help support CHF patients manage the condition outside of the hospital. ORMC hopes to reduce costs for patients diagnosed with CHF and give more accessible and affordable care through development and compliance of self-management goals. In a study promoted by the American Academy of Family Physicians, self-management is a key component in effective chronic illness care and improved outcomes.

Project Components:

Through the development of a CHF/Anticoagulation Clinic, ORMC will meet all required project components.

a) *Development of a multidisciplinary team.* The team will consists of physicians, nurses, pharmacists, and other providers as needed to develop policies and procedures for implementation of the CHF program. Each team member will be called upon to provide feedback and input necessary from each of their specialties. The team will also serve to review outcomes and conduct quality improvements utilizing the Plan-Do-Check-Act cycle.
b) *Identify patients in need of CHF treatment and develop a registry to assist in tracking and monitoring progress.* Developing the tool necessary to identify and track patients to be referred to the CHF clinic will be a vital component of its development. The registry will be able to monitor patients and their progress in order to monitor outcomes and ensure patients are complying with treatment goals set forth by them. The registry will also serve as a communication tool for patients to reach their care team via email or phone for support to treatment protocols or questions.
c) *Development of treatment goals.* Treatment goals will serve as a basis for having the patient be active in his/her treatment for their condition. Patient involvement will help support development of goals that are obtainable and ensure compliance with overall treatment. This method has proved effective in empowering patients to take a more active role in their care and increase compliance with their treatment plan.

d) *Continuous Quality Improvement.* ORMC will implement the Plan, Do, Check, and Act model as part of its continuous quality improvement initiative. An analysis of the CHF program will be conducted and reviewed for improvement opportunities, followed by an action plan and timeline for implementation. After implementation is complete, an assessment of the program will be taken for execution into another service line if revealed appropriate.

Relationship to Other Projects:

The development of a CHF clinic would inter-relate to the following projects: expansion of primary care, women's health clinic, mobile clinics, and a decrease in readmissions to the hospital.

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community (especially in the hospital ICU) by addressing congestive heart failure. This condition causes severe health consequences, and is often fatal, so it is an imperative reform when considered in light of patient health outcomes and quality/quantity of life. Between 2005 and 2010, congestive heart failure was the most frequently occurring potentially preventable hospitalization in this region. Potentially preventable hospitalizations led to over $115 million in charges for this condition between 2005 and 2010. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run, making it a high value project.

Milestone and Metric Table

112711003.2.3	*2.2*	*2.2.1*	*DEVELOPMENT OF CHF CLINIC*
ODESSA REGIONAL MEDICAL CENTER		*112711003*	
RELATED CATEGORY 3 OUTCOME MEASURE(S):	*112711003*	*IT 3.2*	*DECREASE CHF READMISSIONS*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3]: Develop a multi-disciplinary team, consisting of: coordinator/navigator, physicians, nurses, pharmacists, and other providers as needed, to develop the Heart Failure/Anticoagulation Care Management Clinic/Program, to compare and analyze clinical/quality data associated with hospital's performance to CHF. **Metric 1 [P-3.1]:** Analysis of findings. **Data Source:** Needs Assessment **Process Milestone 1 Incentive Value: $403,284** **Process Milestone 2 [P-4]:** Identify the patient population for the program based on CHF classification, and define operational procedures needed for process implementation. . **Metric 1 [P-4.1]:** Report defining new procedures and policies to be implemented. **Data Source:** Policy/procedure	**Process Milestone 3 [P-8]:** Train staff (nurses, MD's, ancillary) on the Heart Failure/Anticoagulation Program. **Metric 1 [P-8.2]:** Documentation of In-service and education hours. **Data Source:** In-service sign in documentation **Process Milestone 3 Incentive Value: $290,997** **Process Milestone 4 [P-6]:** Implement the comprehensive Heart Failure/Anticoagulation care management program for Heart Failure patients. **Metric 1 [P-6.1]:** Evidence of established program through program materials, protocols, etc. **Projected Impact:** 750 patients with 187 Medicaid/Indigent **Data Source:** Program Protocols **Process Milestone 4 Incentive**	**Improvement Measure 1 [I-13]:** Increase the percentage of patients seen in the clinic with self-management goals over baseline by 10%. **Metric 1 [I-13.1]:** Patients with self-management goals. **Projected Impact:** 825 patients with 206 Medicaid/Indigent **Numerator:** The number of patients with the specified chronic condition (Heart Failure) in the registry with at least one recorded self management goal. **Denominator:** Total number of patients with the specified chronic condition (Heart Failure) in the comprehensive Heart Failure care management program. **Data Source:** Registry or other data source provided by Performing Provider. **Improvement Milestone 1 Incentive Value: $867,536**	**Improvement Measure 2 [I-13]:** Increase the percentage of patients with self-management goals over baseline year by 15%. **Metric 1 [I-13.1]:** Patients with self-management goals. **Projected Impact:** 862 patients with 215 Medicaid/Indigent **Numerator:** The number of patients with the specified chronic condition (Heart Failure) in the registry with at least one recorded self management goal. **Denominator:** Total number of patients with the specified chronic condition (Heart Failure) in the comprehensive Heart Failure care management program. **Data Source:** Registry or other data source provided by Performing Provider. **Improvement Milestone 2 Incentive Value: $712,074**

documents **Process Milestone 2 Incentive Value: $403,285**	**Value: $290,997** **Process Milestone 5 [P-X]**: Development at least 6 months worth of baseline data for patient encounters and self management goals established through CHF/Anticoagulation clinic. **Metric 1 [P-X.1]:** Registry or other data source provided by performing provider. **Data Source:** EHR **Process Milestone 5 Incentive Value: $290,999**		
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $868,613	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $940,146	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $934,270	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $766,849
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $3,509,878			

Identifying Information

Title of Project: Establish a Patient Care Navigation Program
RHP Project Identification Number: 112711003.2.4
Reference Number of Project Option Planning Protocol: 2.9.1
Performing Provider Name/TPI: Odessa Regional Medical Center

Summary Information:

- Provider: Odessa Regional Medical Center ("ORMC") is a 230-bed hospital providing a full range of hospital services to the city of Odessa, Texas and its surrounding communities. ORMC primarily serves Ector and Midland Counties, an 1800 square mile area with an estimated population of 280,000. As of October 2012, Ector and Midland Counties had a total Medicaid enrollment of approximately 32,000 individuals (18,795 and 12,906 respectively). ORMC is part of IASIS Healthcare® LLC, which owns and operates five hospitals in Texas.

- Intervention(s): ORMC's goal is to develop a program that can assist an identified group of patients that are in need of guidance in their medical care. This program will assist in directing patients to the appropriate level of care based on their medical needs. Currently ORMC has identified high frequency Emergency Department users as a candidate for developing this program around. This patient population will be confirmed through an internal-need assessment conducted in DY2.

- Need for the project: Currently preventable hospitalizations is key to help drive down costs for both patients and providers. Lower income patients are at an increased possibility to be unaware of their healthcare options and would benefit from establishment of this program.

- Target population: In particular, this project will target the approximately 35% of ORMC patients covered under Medicaid or considered indigent.

- Category 1 or 2 expected patient benefits: ORMC will look to increase patients enrolled within the patient navigation program, helping enrollees better assess the healthcare options available.

- Category 3 outcomes: IT 9.2- ED appropriate utilization - Through the establishment of a patient navigation program, ORMC will be better able to manage patients they have identified as high utilizes within their Emergency Department and guide to more appropriate care.

Project Description:

Preventable hospitalizations occur more commonly than anticipated, which results in a consumption of healthcare resources that is a costly and potentially preventable. While recognizing that these visits may at times be unavoidable, preventable visits may also occur due to a lack of coordination/ facilitation post-discharge. A patient care navigation program would help mitigate preventable hospital visits, especially those which are the result of a lack of coordinated post-hospitalization care. Early follow-up with the patient's primary care provider is encouraged but, for various reasons, not always acted upon by the patient. In addition, a patient care navigation program, focused on the patient's immediate post discharge needs, improves patient satisfaction, promotes patient self-management, enhances an understanding of their condition and treatment, and reduces the risk of negative outcomes post-discharge. In order to achieve this, ORMC will hire patient navigators that will focus on an identified patient population. These navigators will discuss post discharge instructions, ensure compliance with their healthcare regime, and guide patients in regards to follow up care.

Project Goal(s) and Relationship to Regional Goals:

ORMC hopes to help and support patients especially in need of coordinated care navigate through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between healthcare settings.

Through the establishment of a patient navigator program, ORMC plans to: reduce readmissions from the targeted patient population, reduce unnecessary emergency department utilization by targeted population, and redirect patients to appropriate level of care. The project will address the following regional needs: Access to primary and specialty care (CN13), navigation to proper site of care (CN17), and enhancing the overall patient experience (CN19).

Challenges/Issues Faced By Provider:

- Staff skepticism in making the calls (resolve with successes, lives saved).
- Identifying requirements for patient navigator skill set
- Possibility of delays
- Confidentiality issues related to leaving messages on voicemails, answering machines, etc.
- Information levels given to patients (confusion, anger, etc.)

5-year Expected Outcome:

Population identified will have reduced readmissions, reduced unnecessary emergency department utilization, and better access to appropriate levels of care. Based on previous years, ORMC expects to have the following impact:

Year 3: 2,400 patients served with 1,000 being Medicaid/indigent
Year 4: 2,640 patients served with 1,200 being Medicaid/indigent
Year 5: 2,760 patients served with 1,400 being Medicaid/indigent
Total amount of patients served is expected to be approximately 7,800.

Starting Point/Baseline:

This will be a new program for Odessa Regional Medical Center.

Rationale:

This project meet CN1 and CN2 as identified in the RHP 14 Community Needs Assessment.

Patient care navigation has been established as a best practice to improve the care of the high risk populations being disconnected from healthcare institutions. The patient's condition is able to be followed up on in a quicker and more affordable environment of care, relieving congestion in hospitals for more acute patient needs. Increased patient engagement in such activities can empower patients with the knowledge, information, and confidence to better self-manage their conditions, helping the patients to stay healthy. Avoidable hospitalizations and excessive use of ED are seen as key measures of patients' disconnect from the health care systems.

According to the Regional Healthcare Partnership 14 Community Needs Assessment (July 2012), 23% of the population in Public Health Region 9/10, including RHP 14, 18 years and older, reported that they could not see a doctor in the past 12 months due to costs. According to the Texas Behavioral Risk Factor Surveillance System (BRFSS), the following groups were more likely than their counterparts to report that they were uninsured: Hispanics, younger adults, and those with no high school diploma, and those with income levels less than $25,000. This translates into patients utilizing the ED for episodic care and as a primary care center. Across Texas, Emergency Department visits increased by 28.6% between 2001 and 2010, and Public Health Region 9, which covers RHP 14 counties had a similar hospital utilization rates.

Project Components:

Through the establishment of a patient navigation program, ORMC will meet the following components:

a) *Identifying a population most in need of navigation services.* The navigation program will be based upon an identified population that would benefit the most from its development. This patient population will be identified through our current EHR capacity.

b) *Develop and identify personnel to become a patient navigator*. The patient navigator position will need to be trained or have a background in several areas, including: nursing, social services, and case management.

c) *Develop a network of health care providers for referrals of patients within the navigator program*. In order to be able to direct patients to the appropriate area of care, a referral network consisting of primary care physicians, specialty physicians, and other providers will need to be on board. This established group will be able to support the patients and manage the care they need.

Related Category 3 Outcome Measure: [IT-9.2] ED Appropriate Utilization

Relationship to Other Projects:

The patient care navigation program would relate to the following projects: Expansion of primary care capacity, redesigning primary care, expansion of chronic care management models, and the implementation of evidenced-based health promotion and disease prevention programs. Through these related projects, ORMC will continue its goal of managing patient's health in a less costly environment.

Project Valuation:

The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community (especially in the hospital ICU) by addressing potentially preventable hospitalizations. Between 2005 and 2010, potentially preventable hospitalizations led to over 24,000 patient visits and resulted in approximately $461 million in charges. These conditions cause severe health consequences, waste patient time, and waste limited health resources. This is an imperative reform when considered in light of patient health outcomes and quality/quantity of life. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run, making it a high value project.

112711003.2.4	*2.9*	*Expand Chronic Care Management Model for Diabetes care (2.9.1)*	*Establish a patient navigation program*
Odessa Regional Medical Center			*112711003*
Category 3 Outcome Measure(s):		*112711003.3.13*	*IT-9.2*	*Decrease unnecessary ED usage*
Process Milestone 1 [P-1] : Conduct a needs assessment to identify the patient population to be targeted with the patient navigator program. **Metric 1 [P-1.1]:** Needs Assessment. **Source:** Assessment **Process Milestone1 Incentive Payment:** $434,306 **Process Milestone 2 [P-X]:** Identify necessary resources for implementation of patient navigation program, such as necessary amount of patient navigators to be hired. **Metric 1 [P-X.1]:** Needs assessment **Source:** Assessment **Milestone Incentive Payment:** $434,307	**Process Milestone 3 [P-2]:** Establish a healthcare navigation program to provide support to patient populations identified in needs assessment conducted in DY1. **Metric 1 [P-2.1]:** Evidence of program as documented by hospital procedures/protocols Data Source: Program Materials, EHR **Process Milestone 3 Incentive Payment:** $313,382 **Improvement Milestone 1 [I-X]:** Establish baseline measure (at least 6 months) for identified population visits and/or avoidable hospitalizations for patients enrolled in the navigator program. **Metric 1 [I-X.1]:** Number of visits or avoidable hospitalizations. **Data Source**: EHR/Registry **Improvement Milestone 1 Incentive Payment:** $313,382	**Improvement Milestone 3 [I-8]:** Reduction in hospital utilization by identified patient population receiving navigation services by 10%. **Metric 1 [I-8.1]:** Hospital utilization for pre and post navigation services by individuals identified. **Data Source:** EHR/Registry **Improvement Milestone 3 Incentive Payment:** $467,135 **Improvement Milestone 4 [I-10]:** Increase number of encounters made through the patient navigation program by 10% compared to baseline year of DY 3 **Metric 1 [I-10.1]:** Increase percentage of target population reached. **Projected Impact:** 2,640 patients with 1,200 Medicaid/Indigent **Data Source:** EHR/Registry **Improvement Milestone 4 Incentive Payment:** $467,135	**Improvement Milestone 5 [I-8]:** Reduction in hospital utilization by identified patient population receiving navigation services by 15% compared to baseline year of DY3. **Metric 1 [I-8.1]:** Hospital utilization for pre and post navigation services by individuals identified. **Data Source:** EHR/Registry **Improvement Milestone 5 Incentive Payment:** $383,424 **Improvement Milestone 6 [I-10] :** Increase number of encounters made through the patient navigation program by 15% compared to baseline year of DY3 **Metric 1 [I-10.1]:** Increase percentage of target population reached. **Projected Impact:** 2,760 patients with 1,400 Medicaid/Indigent **Data Source:** EHR/Registry **Milestone Incentive Payment:** $383,425

	Improvement Milestone 2 [I-X]: Establish baseline number of patient encounters by patient navigation program. **Metric 1 [I-X.1]:** Number of patients documented within patient navigation program **Projected Impact:** 2,400 patients with 1,000 Medicaid/Indigent **Data Source:** EHR/Registry **Improvement Milestone 2 Incentive Payment:** $313,382		
Year 2 Estimated Milestone Bundle Amount: $868,613	Year 3 Estimated Milestone Bundle Amount: $940,146	Year 4 Estimated Milestone Bundle Amount: $934,270	Year 5 Estimated Milestone Bundle Amount:$766,849
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$3,509,878			

Identifying Project and Provider Information
Unique Category 2 Identifier: 136145310.2.1
Project Option: 2.2.1 -- Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.
Performing Provider: Martin County Hospital District TPI: 136145310

Summary

- Provider: Martin County Hospital District is a rural 18-bed Critical Access hospital in Stanton, TX. MCHD serves Martin County which has a population of 5,368 residents.

- Intervention(s): This program will utilize care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system. This program will expand the chronic care management of the diabetic patient with increased patient engagement by launching a diabetic self-management outreach education program that will empower the diabetic patient to make lifestyle changes, stay healthy, and manage their chronic condition.

- Need for the project: Currently there is a severe unmet need for a comprehensive self-management education program for patients in Martin County with chronic diabetic conditions. Self-management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. By providing the residents of Martin County with a comprehensive self-management program, clinical outcomes are improved, complications can be avoided, and healthcare cost will be reduced by decreasing the need for ER and inpatient management.

- Target population: The target population is any patient that is identified using specific criteria that will be set during DY2. This will more than likely include any patients that are considered to be "high risk" and any patients that have been treated in the Emergency Department or admitted with diabetic complications.

- Category 1 or 2 expected patient benefits: This program aims to decrease the burden of illness and associated cost to the patient and community, improve patient aaccess to local diabetic education services, improve coordination of care that is facilitated locally, and decrease financial burden on the patient associated with poor compliance with therapeutic regimens due to lack of understanding.

- Category 3 outcomes: IT-2.9 our goal is to reduce potentially preventable uncontrolled diabetes admission rates by 5% by DY5. Therefore, our five year expected outcome for

the residents of Martin County and the patients of Martin County Hospital is to provide them with a comprehensive self-management diabetic outreach education program that will meet the needs of the diabetic population in an outpatient setting. This will improve the health and self-management of our diabetic patients therefore reducing the number of ER and inpatient visits for uncontrolled diabetes. This program will help to reduce the high healthcare costs associated with preventable hospital admissions and readmissions, particularly with the chronic diabetic patient. This project also relates to our RHP 14's goals by ensuring that the population of martin county are provided with healthcare options outside of the traditional inpatient setting, as well as, ensuring they have access to high quality diabetic healthcare services regardless of socioeconomic income or location.

Project Description

The goal of this project is to provide diabetic patients with, chronic conditions, proactive ongoing care that keeps the patient healthy and empowers them to self-manage their condition in order to avoid worsening health issues and the need for ER and/or inpatient care.

Challenges: The challenges we face are providing adequate educational resources in the outpatient setting of our rural community. A lack of primary care providers also contributes to limited and insufficient education on lifestyle changes, proper medication management, and preventative measures that are necessary for the diabetic patient to self-manage their chronic condition.

Goals: Our solution to expanding chronic care management of the diabetic patient is to increase patient engagement by launching a diabetic self-management outreach education program that will empower the diabetic patient to make lifestyle changes, stay healthy, and manage their chronic condition. Therefore, our five year expected outcome is to recruit a diabetic educator who will develop and implement a comprehensive self-management diabetic outreach education program that will meet the needs of the diabetic population in an outpatient setting. This will improve the health and self-management of our diabetic patients therefore reducing the number of ER and inpatient visits for uncontrolled diabetes. This program will help to reduce the high costs associated with preventable hospital admissions and readmissions (CN.2), particularly with the chronic diabetic patient (CN.1).

Starting Point / Baseline Data

Currently Martin County Hospital does not have a diabetic self-management outreach program or a trained diabetic educator. Currently Martin County Hospital only has one dietician that is in house for 8-hours one day a month. When she is on campus, the only diabetic education that is provided is diet specific. Over a five year period (2005-2010) potentially preventable diabetic hospitalizations in RHP 14 totaled more than $60,000,000. By implementing this diabetic outreach program, we can decrease the risk of serious medical conditions associated with diabetes that lead to unnecessary inpatient admissions, increased healthcare cost, poor health, and premature death.

Rationale

Currently there is a severe unmet need for a comprehensive self-management education program for patients in Martin County with chronic diabetic conditions. Self-management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. By providing the residents of Martin County with a comprehensive self-management program, clinical outcomes are improved, complications can be avoided, and healthcare cost will be reduced by decreasing the need for ER and inpatient management.
We will be including initiatives related to the core components for Project Option 2.2.1. See below how we will plan to address these.

Required core 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.

b) Ensure that patients can access their care teams in person or by phone or email.

c) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources.

d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.

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.

Related Category 3 Outcome Measure
OD-2-Potentially Preventable Admissions: IT-2.9 (Uncontrolled Diabetes Admission Rate)

This project relates to Category 3 Outcome Measure OD-2, Subcategory IT-2.9 (Uncontrolled Diabetes Admission Rate) by reducing potentially preventable healthcare complications by empowering the patient through in-depth education through a comprehensive diabetic self-management program. By providing this program diabetic patients will be able to more effectively manage their chronic condition, reduce complications, and therefore decreases the need for inpatient management. By providing focused education on all aspects of diabetes management, the patient will be better able to comply with prescribed therapeutic regimens that promote wellness and therefore potentially reduce preventable diabetic complications.

Relationship to other Projects
N/A

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

Plan for Learning Collaborative

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation

Martin County Hospital District understands and values the importance of providing our patients with proper resources to effectively manage their diabetes. By implementing the diabetic self-management program, we are able to improve patient outcomes, promote wellness among our diabetic patient population, reduce healthcare cost, and improve overall patient satisfaction in our service area. For this reason, Martin County Hospital District is seeking to implement a diabetic self-management outreach program that will meet the educational and healthcare needs of our diabetic patient population. We will make this investment in staffing and training initiatives to transform the system of care in Stanton. Our community has supported the Hospital District through taxes and seeks to leverage funds to find more cost efficient and quality care treatment plans to better address the ongoing health disparities for at-risk populations.

Benefits to the Diabetic Patient Population of Martin County include:

- Decreased burden of illness and associated cost to the community
- Access to local diabetic education services
- Improved coordination of care that is facilitated locally
- Decreased financial burden on the patient associated with poor compliance with therapeutic regimens due to lack of understanding.

136145310.2.1	***2.2.1***	***2.2.1 A, B, C, D, E***	***2.2.1 -- REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES.***
Martin County Hospital District		*TPI: 136145310*	
Related Category 3 Outcome Measure(s):	*136145310.3.1*	*OD-2 IT-2.9*	*Potentially Preventable Admissions: (Uncontrolled Diabetes Admission 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-11]: Develop and implement a program to assist patient to better self-manage their chronic condition. Metric 1: [P-11.1]: increase the number of patients enrolled in a self-management program. Goal: development and documentation of a diabetic self-management program. Data Source: EHR, patient registry, class enrollment, and attendance records. Milestone 1 Estimated Incentive Payment (maximum amount): $326,885	Milestone 2 [I-18]: Increase the percentage of patients with self-management goals. Metric 1 [I-18.1]: patients with self-management goals. Goal: Increase the number of patients with self-management goals by 2% above baseline. Data Source: registry Milestone 2 Estimated Incentive Payment (maximum amount): $378,902	Milestone 2 [I-18]: Increase the percentage of patients with self-management goals. Metric 1 [I-18.1]: patients with self-management goals. Goal: Increase the number of patients with self-management goals by 3% above baseline. Data Source: registry Milestone 3 Estimated Incentive Payment (maximum amount): $382,818	Milestone 2 [I-18]: Increase the percentage of patients with self-management goals. Metric 1 [I-18.1]: patients with self-management goals. Goal: Increase the number of patients with self-management goals by 5% above baseline. Data Source: registry Milestone 4 Estimated Incentive Payment (maximum amount): $327,990

Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $326,885	Year 3 Estimated Milestone Bundle Amount: $378,902	Year 4 Estimated Milestone Bundle Amount: $382,818	Year 5 Estimated Milestone Bundle Amount: $327,990
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,416,595			

Identifying Project and Provider Information:
RHP project identification number: 094172602.2.1
Project Title: Diabetes Transition of Care, 2.12, Implement Care Transitions Program.
Performing Provider: McCamey County Hospital District TPI: 094172602.

Summary Information:

- Provider: McCamey County Hospital District is a 14 bed Critical Access Hospital. The population of McCamey is 1887; the hospital also serves additional patients from the 20 square mile rural area.
- Intervention(s): This project will implement consulting for newly diagnosed and uncontrolled diabetes patients.
- Need for the project: The nearest centers the patients can receive similar services is a 50 mile drive from McCamey.
- Target population: The target population is our patients that are newly diagnosed or have uncontrolled diabetes. Our Medicaid and indigent percentage in this category is 12%.
- Category 2 expected patient benefits: The project seeks to provide 100 consults in DY4 and 125 in DY5.
- Category 3 outcomes: IT-1.10 our goal is to reduce the patients HbA1c in order to improve their overall health and readmissions to the hospital.

Project Description:

We plan to implement a pilot intervention for diabetic patients to improve HbA1C for those with uncontrolled diabetes, or newly diagnosed patients. Develop procedures to identify patients with uncontrolled diabetes, as well as those who are newly diagnosed. Establish wellness initiatives that target these patients. Educate patients on resources being provided by the hospital district for education and for exercise. We have chosen 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. Implementation of:

- Wellness initiatives targeting high-risk patients

As noted in the planning protocol all of the project options in project area 2.12 should include a component to conduct quality improvement for the project. We plan to include a process to identify project impacts, “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations. The Nursing CQI will create a monitor tool with the following indicators:

- Initial Diagnosis
- Hospital Lab Results
- Patients compliance on keeping appointments with Dietician
- 90 & 180 day compliance with physician follow up
- 90 & 180 day lab results. Will be seeking lab results that reflect an improvement in the HgbA1C.

Failure of goal or compliance issues will be documented through an action tool. The tool will also include any input from the physician on compliance issues.

Starting Point/Baseline Data

We have evaluated our current patient population and have determined that newly diagnosed diabetes, as well as uncontrolled diabetes, is a factor that is negatively affecting our population. We are looking at an intervention that would allow our patients to have local access to a resource that is currently not available to them. The nearest resource for this is currently in Odessa, 50 miles away.

Rationale:

- **This project meets CN1 as identified in the RHP 14 Community Needs Assessment.**

When a patient's transition is less than optimal, the repercussions can be far-reaching hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Our plan is addressing community need number 9, Diabetes Screening and Education. We plan to develop protocols for effectively communicating with patients and families the availability of resources for those that are newly diagnosed with diabetes or those with uncontrolled diabetes. We will establish monthly classes with a dietician, at no cost to the patient. We will also offer diabetes specific exercise classes, also at no charge. Patients will receive orders from the physician in order to attend these classes. We will establish a process for hospital-based managers to follow up with identified patients hospitalized related to diabetes 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. Clinic patients will be identified during their visit to the clinic.

Relationship to other Projects

This project will relate with Category 3 Project OD-1, IT 1.10, Primary Care and Chronic Disease Management, HbA1C poor control.

Project Valuation

The Hospital District will have to contract with a dietician for monthly meetings. This cost will include not only meeting hours but travel time and costs. These costs are not yet determined, as it will need to be negotiated when a dietician is found. A trainer will be required to hold the classes at the Wellness Center. The cost of getting an employee trained and if possible certified in diabetic wellness is to be determined. The cost of the trainer's time and use of the classroom is estimated to be $3,000 per year. Other education material will also be purchased; this is estimated to be around $1,000 per year. The American Diabetes Association estimates costs at $174,000,000,000 for the 25.8 million people in the U.S. with diabetes. This cost averages at $6,745 per person with diabetes. Our current reports show the Hospital District has 66 patients with newly diagnosed or uncontrolled diabetes. Using the national average this calculates to $445,170 of cost avoidance. Also if we are able to improve the patients quality of life that will be a tremendous benefit in a community with such a small population.

Milestones and Metrics Table

094172602.2.1	***2.12***	***2.12.2***	***Diabetes Transition of Care***
McCamey County Hospital District		***09417602.2.1***	
Related Category 3 Outcome Measure(s):	***09417602.3.1***	***IT-1.10***	***Diabetes care: HbA1c poor control***
Year 2	Year 3	Year 4	Year 5
Process 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 Data Source: Submission of protocols Process Milestone 1 Estimated Incentive Payment (maximum amount): $10,000	Process Milestone 2 [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 [P-7.1]: Documentation of staffing plan Data Source: Staffing and Implementation Plan Process Milestone 2 Estimated Incentive Payment (maximum amount): $12,000	Improvement Milestone 1 [I-14]: Implement standard care transition processes in specified patient populations. Metric 1: [I-14.1]: Measure adherence to processes. Goal: TBD% Increase Data Source: Hospital administrative data and the patient medical record. Improvement Milestone 1 Estimated Incentive Payment (maximum amount): $13,000	Improvement Milestone 2 [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 Goal: TBD% Increase Data Source: Improvement Milestone 2 Estimated Incentive Payment (maximum

			amount): $13,000
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $10,000	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $12,000	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $13,000	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $13,000
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5):$48,000			

Identifying Project and Provider Information:
Project Title and Option: 2.15.1 Integrate Behavioral Health Care and Primary Care
Unique Category 2 Identifier: 138364812.2.1
Performing Provider: Permian Basin Community Centers (PBCC)/138364812

Summary Information

Provider: Permian Basin Community Centers (PBCC) is one of 39 community centers in the state that contracts with DSHS as the Local Mental Health Authority. Its service area covers 6 counties in RHP 14 with a total population of 292,488, 92% of which are in Midland and Ector counties. It also covers two other counties included in two other RHP's.

Intervention: This project will be a full integration of primary care into two of the existing behavioral health care clinics by adding medical staff and equipment to existing space, after minor re-modeling, or by acquiring space within very close proximity to the existing clinic.

Target Population: DSHS primarily funds PBCC services to individuals with a diagnosis of Bipolar, Major Depression or Schizophrenia – the Serious and Persistently Mentally Ill. Of those served by PBCC, 34% are Medicaid eligible and 44% are indigent. This project will serve the physical health needs of this population by being within close proximity - making it very accessible for these more fragile individuals.

Need for Project: The physical health needs of these individuals are not currently addressed, although the statistics show that they have high rates of chronic disease. Their mental illness often prevents their seeking preventive and regular physical healthcare at the FQHC's in the area.

Category 1 expected benefits: This project intends to provide primary care to 480 persons annually.

Category 3 outcomes: 3.IT.10.1 goal is to improve the Quality of Life by an amount to be determined in FY 3.

Project Description:
*PBCC intends to fulfill core components a-j identified in project option 2.15.1 of the planning protocol.

Permian Basin Community Centers (PBCC) intends to integrate primary care into the center's two largest behavioral health care clinics. These 2 clinics combined currently serve approximately 1,200 individuals with Serious and Persistent Mental Illness. The goal is to have primary care physicians, and/or mid-level practitioners, case management, and support staff directly integrated into PBCC's existing mental health care clinics, or in very close proximity, in

order to provide a more cohesive continuum of care between behavioral health and primary care. This will require re-tooling current space in the two clinics to accommodate the medical equipment and additional providers that will be needed for primary care, or acquiring additional leased space. Proximity and accessibility will be part of the selection criteria, as well as the ability to share data electronically. It will involve adding utilities and building services.

PBCC intends to collaborate with local hospitals, hospital districts and physician groups, private providers, and tele-health providers to obtain, by means of legal contracts, primary care practitioners and support staff. PBCC will ensure that provider agreements include co-scheduling and information sharing. When appropriate, PBCC will employ rather than contract for these staff.

Protocols will be established, utilizing technology to as high a degree as possible. PBCC's Information Technology (IT) Department will ensure that providers have access to integrated clinical information including such things as lab orders and results, diagnosis, scheduling and prescription history. IT will also develop shared databases to ensure communication and collaboration. Workflows and procedures will be developed to facilitate communication and referrals of the shared clients. Reports of utilization of integrated services and healthcare outcomes will be incorporated into the already regularly scheduled meetings of PBCC's Utilization Management Committee that includes the PBCC Medical Director.

PBCC will recruit and train these primary care providers on mental health issues through professional staff mentoring and peer review meetings. PBCC already conducts regular Physician Meetings, and the primary care practitioners will be included in those. Joint training needs will be identified and prioritized in these meetings. The peer review and Physician Meetings will include such agenda items as patient concerns, review of service delivery, review of treatment plan goals and objectives, best practices and patient outcomes.

The co-location of behavioral health and physical health services will provide opportunities to address both conditions in an environment that promotes communication between providers, and increases the likelihood that behavioral health patients will follow up with treatment for their physical health issues. Local Mental Health Authority (LMHA) staff will work in collaboration with medical case managers to establish a "warm handoff" that can be tracked in order to maximize the value of available services.

Continuous Quality Improvement (CQI) is a concept that is fully integrated into PBCC operations as outlined in its Quality Management (QM) Plan, and implemented by 3 full-time QM Coordinators. The QM staff will conduct regular meetings with the IT, Fiscal and Data Management staff to develop plans, reports, etc. to inform the process of Plan, Do, Study, Act and Rapid Cycle Change Testing.

PBCC's goal is to integrate the related components of physical and behavioral health care so that care can be better coordinated, and the patient can be treated as a whole person. This integration leads to better outcomes and experience of care, while greatly improving the

Quality of Life. The sites will be integrated by the end of DY 3, approximately 240 patients will be receiving newly integrated services by DY 4, and approximately 480 patients by DY 5.

The primary challenge for PBCC will be recruiting, hiring (or contracting with), and training licensed staff to provide services in this rural area of West Texas. The clinic hours will depend on the availability of the primary care providers. Ideally, the hours of operation will be flexible to provide increased hours of access to working clients.

Starting Point/Baseline:

Evidence suggests that a significant portion of the severe and persistently mentally ill population does not receive adequate primary care treatment for diagnosed or potential existing medical conditions.

PBCC serves approximately 600 persons in each of its two largest clinics. Currently, PBCC offers no primary care for these persons.

Rationale:

Individuals with chronic mental disorders are at risk of reduced access to medical treatment and poor quality of medical care. Medical mortality and morbidity is elevated among patients with serious mental disorders (Psychiatric Services, VOL 54, No.8 – *Barriers to Primary Medical Care Among Patients at a Community Mental Health Center).* Without an adequate and reliable system of care integrating mental health and primary care, many patients suffering from chronic mental illness consume costly community resources (i.e. Emergency Department resources) for medical conditions that could have been preventively managed on an outpatient basis by a primary care physician.

PBCC's goals are to increase the percent of patients who complete lab work ordered by specialty care providers, and improve the percentage of persistently mentally ill patients who have access to primary care. Patients treated in an integrated care clinic are significantly more likely to follow up with a primary care visit and to have a greater mean number of primary care visits than patients treated in non-integrated clinics (Archives of General Psychiatry, September 2001, Vol 58, No.9) PBCC is only funded by the Department of State Health Services (DSHS) to provide behavioral health.

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. **See Addendum 4.**

There exists a shortage of primary care physicians in the Permian Basin. Primary care physicians with availability primarily treat patients with third party payers, or those who have the financial ability to pay privately. However, PBCC's patient population is largely indigent. The issue is further complicated by difficulty in obtaining and exchanging information with primary care physicians in the community, and by non-compliance issues that are prevalent among the patient population that PBCC serves.

This project addresses the following Community Needs:

CN1. High rates of chronic disease
CN2 High costs associated with preventable hospitalization admissions and readmissions
CN3. Shortages of health care professionals, including primary care physicians and mental health care providers.

**PBCC intends to fulfill core components a-j identified in project option 2.1 of the planning protocol.*

Related Category 3 Outcome Measures:

This project is related to Category 3, OD-10, "Quality of Life". Although much of health care is focused on increasing longevity, many treatments are specifically designed to improve symptoms and functions, two essential components of health – related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey.

Project planning and conducting Plan Do Study Act (PDSA) are essential in laying the ground work for the development of successful demonstration projects that are designed to operate under continuous improvement monitoring. Data will be collected in simple interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purpose of improvement.

There is evidence that Health Related Quality of Life (HRQOL) predicts outcomes among patients. A study of 1,000 patients at three dialysis facilities in the United States reported an association between lower scores in the physical component of quality of life and higher risk of death and hospitalization. A larger study, involving 5,256 patients at 243 facilities in the United States and Europe presented evidence that psychological or mental components of quality of life predict death in hemodialysis patients. Self – reported depression was significantly associated with a higher risk of death and hospitalization (Kidney International, "Health Related Quality of Life, as a predictor of mortality and hospitalization: The Dialysis Outcomes Practice and Patterns Study (DOPPS), *Kidney International* (2003) 64, 339–349; doi:10.1046/j.1523-1755.2003.00072). It is PBCC's contention that the same principles apply to behavioral health and other primary care ailments, and that affecting QOL will improve patient outcome and output measures leading to decreased utilization of costly inpatient and emergency medical care.

As explained in paragraphs one and three above for the rationale for this project the individuals that will benefit from this project are historically indigent or underfunded (i.e. Medicaid), and would not have access to these services and outcomes withstanding funds available through the 1115 waiver

Relationship to other Projects:

The integration of primary care practioners into behavior health clinics will be accomplished through the use of expanded telemedicine and primary health capacity by using quality improvement tools to improve and measure performance. The following category projects relate: Category 1 projects: 1.1, 1.2, 1.7, 1.10, 1.11, and 1.12

The integration of primary care and behavioral health will be accomplished by full development of the care management function in order to achieve a medical home for the

individuals served. The following category projects relate: Category 2 projects: 2.1, 2.3, 2.4, 2.8, and 2.19

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative:

RHP 14 intends to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Permian Basin Community Centers (PBCC) proposes to create one or more integrated behavioral health and primary care outpatient clinics in community-based, easily accessed locations. Persons with acute behavioral health needs often simultaneously have a high incidence of chronic diseases such as diabetes, COPD, and hypertension.

The following valuation is based on work prepared by H. Shelton Brown, Ph.D., A. Hasanat Alamgir, Ph.D., UT Houston School of Public Health and Thomas Bohman, Ph.D., UT Austin Center for Social Work Research.

It uses the method of cost-utility analysis (a type of cost-effectiveness research), as well as additional information on potential future costs saved.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature. **See Addendum 4– Rationale for Economic Valuation**.

Since integrated healthcare is synonymous with collaborative healthcare, the term "collaborative healthcare" will be used in this valuation to be consistent with the literature referenced.

Cost-Utility Analysis:

One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.018 incremental life years gained. After quality-adjusting, **.335 Quality adjusted life-years** were added. Assuming the program would serve 480 persons in a year, the following formula shows the total valuation:

	480	(persons served)
x	0.335	(QALY gained)
x	$50,000	(life year value)
=	$8,040,000	(annually)
x	4	(years)
=	$32,160,000	total

Cost-Effectiveness and Cost Savings:

Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. Simon et al. (2012) found that collaborative care yielded 47.7 additional depression-free days per year at a cost of $52 per depression-free day. Based on this CEA,

	480	(persons served)
X	47.7	(depression-free days)
X	$52	
=	$1,190,592	(annually)
X	4	(years)
=	$4,762,368	total

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD (See Addendum 4).

Based on RHP 14's average hospital cost of $18,852 (See Addendum 4), the cost savings would be:

480 persons served x $18,852 = $9,048,960 annually or $36,195,840 over 4 years.

Summary and Total Valuation:

This valuation analysis shows that the intervention will have a positive value for participants who receive the interventions. The total valuation is between $32,160,000 and $36,195,840, but no less than the $8,723,286 projected value. There is additional supporting evidence that the intervention will lead to increased depression-free days.

References:

Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch. Gen Psychiatry, 69(5),* 506-514.

Simon, G. E., Manning, W. G., Katzelnick, D. J., Pearson, S. D., Henk, H. J., & Helstad, C. S. (2001). Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. *Arch Gen Psychiatry, 58(2),* 181-187.

138364812.2.1	2.15.1	*2.15.1: A, B, C, D, E, F, G, H, I, J*	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
Permian Basin Community Centers(PBCC)				*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.3	*3-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 : (Cat 2, pg. 320, P-1) Conduct needs assessment to determine areas of the state where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs <u>Metric 1</u> **(Cat 2, pg. 320, P-1.1)** Number of patients in various areas who might benefit form integrated services, Demographics, location, and diagnoses. PBCC's baseline for this project is to be established as to # of patients receiving integrated care. Baseline: PBCC's baseline for project 2.15.1 is to be established as there are no integrated clinics in the Permian Basin as of October 1, 2012 Data source: inpatient, discharge and ED records; survey of primary and/or behavioral health care providers; state demographic information relating to treated health conditions; Medicaid claims data	**Milestone 3**: **(Cat 2, pg 321, P-5)** Develop integrated sites reflected in the number of locations and providers participating in the integration project <u>Metric 1</u> **(Cat2, pg 321, P-5.2)** Number of primary care providers newly located in or very close to behavioral health settings Goal: Primary care providers located in or in very close proximity to 2 behavioral health clinics Data Source: Project data Milestone 2 Estimated Incentive Payment: $990,918 **Milestone 4**: **(Cat 2, pg 321, P-7)** Evaluate and continuously improve integration of primary and behavioral health services <u>Metric 1</u> **(Cat 2, pg 321, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles		**Milestone 5: (Cat 2, pg 324, I-8)** Integrated services <u>Metric 1:</u> **(Cat 2, pg 324, I-8.1)** X% of individuals receiving both physical and behavioral health care at the established locations **a. Numerator:** Number of individuals receiving both physical and behavioral healthcare at the project sites **b. Denominator:** Number of individuals receiving behavioral services in the project sites Goal: 50% of baseline or 240 individuals will be receiving both physical and behavioral health care at the established locations Data Source: Project data, claims and encounter data, medical records Milestone5 Estimated Incentive Payment: $1,063,399	**Milestone 7: (Cat 2, pg 324, I-8)** Integrated services <u>Metric 1:</u> **(Cat 2, pg 324, I-8.1)** X% of individuals receiving both physical and behavioral health care at the established locations **a. Numerator:** Number of individuals receiving both physical and behavioral healthcare at the project sites **b. Denominator:** Number of individuals receiving behavioral services in the project sites Goal: 100% of baseline or 480 individuals will be receiving both physical and behavioral health care at the established locations Data Source: **(Cat 2, pg 324, I-8.1,c)** Project data, claims and encounter data, medical records

138364812.2.1	2.15.1	*2.15.1: A, B, C, D, E, F, G, H, I, J*	*INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES*
Permian Basin Community Centers(PBCC)			*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.3	*3-IT-10.1*	*Quality of Life*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,275,490 **Milestone 2 (Cat 2, pg. 321, P-7)** Evaluate and continuously improve integration of primary and behavioral health services Metric 1 **(Cat 2, pg. 321, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: N/A (QI measure) Data Source Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts' or monthly dashboards to drive improvement) Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,275,489	Goal: N/A (QI measure) Data Source: Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts' or monthly dashboards to drive improvement) Milestone 4 Estimated Incentive Payment: $990,918	**Milestone 6**:**(Cat 2, pg 321, P-7)** Evaluate and continuously improve integration of primary and behavioral health services Metric 1 **(Cat 2, pg 321, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: N/A (QI measure) Data Source: Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts' or monthly dashboards to drive improvement) Milestone 6 Estimated Incentive Payment: $1,063,399	Milestone 7 Estimated Incentive Payment: $1,031,837 **Milestone 8**: **(Cat 2, pg 321, P-7)** Evaluate and continuously improve integration of primary and behavioral health services Metric 1 **(Cat 2, pg 321, P-7.1)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: N/A (QI measure) Data Source Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts' or monthly dashboards to drive improvement) Milestone 8 Estimated Incentive Payment: $1,031,836

138364812.2.1	**2.15.1**	***2.15.1: A, B, C, D, E, F, G, H, I, J***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***
Permian Basin Community Centers(PBCC)			*138364812*
Related Category 3 Outcome Measure(s):	138364812.3.3	*3-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: (add incentive payments amounts from each milestone): 2,550,979	Year 3 Estimated Milestone Bundle Amount: 1,981,836	Year 4 Estimated Milestone Bundle Amount: 2,126,798	Year 5 Estimated Milestone Bundle Amount: 2,063,673
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5): $8,723,286*			

Identifying Project and Provider Information:
Project Title/Category: Reeves County Hospital District Diabetes Quality Enhancement Program Category 2.2.2 Expand Chronic Care Management Models
Unique Identifier: 112684904.2.1
Performing Provider: Reeves County Hospital District/TPI: 112684904

Summary Information
Provider: Reeves County Hospital District is a 25 bed-critical access Hospital located in Pecos, TX. Reeves County Hospital District provides health care services primarily to the citizens of Reeves County and several adjacent West Texas communities located in the counties of Ward, Culberson, Jeff Davis, and Presidio.

Interventions: This project will implement a Certified Diabetes Education Program geared toward helping those patients diagnosed with diabetes to better manage their chronic condition.

Need for Project: Currently, within Region 14 it is estimated that 10% of the adult population age 20 and above have diabetes. This percentage of the population within Region 14 contributed to the 3,011 potentially preventable Hospital admissions between the years of 2005 to 2010 associated with both short term and long term diabetes related complications. Other than providing primary care services for diabetic patients, Reeves County Hospital District has no formal program in place to help those patients better manage their diabetes.

Relationship to Regional Goals: Diabetes rates in RHP 14 are among some of the highest in the State and that is without reaching 30-40% of our population according to different experts in our Region. In addition to the Reeves County Hospital District Diabetes Quality Enhancement Program, many of the other providers within RHP 14 that are taking part in the DSRIP initiative have diabetes projects. This proliferation of diabetes projects underscores the epidemic problem that diabetes presents for our RHP. The other diabetes projects that are being conducted throughout the Region are as followed: Medical Center (Ector County) [135235306.2.5], Midland Memorial (Midland County) [136143806.2.2], McCamey (Upton County-09417602.2.1), Martin County (136145310.2.1), Odessa Regional (Ector County-112711003.2.3), and TTUHSC (081939301.2.1 & 2.2). Lastly, RHP 14 has established a high rate of chronic diseases including diabetes as its community needs number one. Hopefully, with such a massive effort, our Region will be successful in positively impacting the problem of diabetes.

Target Population: The target population for the Reeves County Hospital District Diabetes Quality Enhancement Program will be all patients whom utilize the Pecos Valley Rural Health

Clinic, whom have been diagnosed with type 1 or type 2 diabetes currently estimated at 1,376 patients. This project will provide those patients with access to a certified diabetes education program. As a part of this program the Hospital shall establish self management goals for 5% of the approximate 1,376 diabetic patients for DY 4 and 10% of the approximate 1,376 diabetic patients for DY 5. This includes the percentage of Medicaid patients within the region estimated at 15% or 2,394 total patients and those considered indigent estimated at .88% or 140 total patients for 2011.

Category 1 or 2 expected patient benefits:
The project seeks to increase the total number of patients diagnosed with type 1 or type 2 diabetes within the target population that have self-management goals in DY 4 and DY 5.

Category 3 expected patient benefits:
Ultimately, the Hospital's goal is to increase the number of patients diagnosed with type 1 or type 2 diabetes that have had diabetes care foot exam, nephropathy screening test, retinal eye exam by 5% in DY 4 and by 10% in DY 5.

CQI Element: Reeves County Hospital will utilize its internal CQI infrastructure and reporting processes to conduct rapid cycle improvement with the focus of tracking referrals to the certified diabetes education program completed versus referrals to the certified diabetes education program not completed. The Hospital shall track and trend to determine whether socioeconomic, geographic and/or language barriers negatively affect referrals completed.

Project Description:

As noted on Table Y in the appendix of the attached Regional Healthcare Partnership 14 Community Needs Assessment, between the years of 2005 to 2010 Region 14 had 3,011 potentially preventable Hospital admissions associated with both short term and long term diabetes related complications. This resulted in $66,064,959 of Hospital charges that could have potentially been eliminated. Additionally, as noted on Table X Page 22 in the appendix of the Regional Healthcare Partnership 14 Community Needs Assessment, it is estimated that 10% of the adult population age 20 and above have Diabetes in Region 14.

For these reasons, under the 1115B waiver Reeves County Hospital District shall commence in a project to create and implement a Certified Diabetes Education Program. The ultimate goal of the program is to develop and implement chronic disease management interventions that are geared towards improving effective management of chronic conditions. This will have the ultimate effect of increasing the percentage of adult diabetes patients who have optimally managed modifiable risk factors with the intent of preventing or reducing future complications associated with poorly managed diabetes.

5 Year Expected Outcome

At the end of five years Reeves County Hospital District ultimately expects to increase the percentage of diabetic patients that have self-management goals which equates to

approximately 138 diabetic patients. Additionally, for the corresponding category three project the Hospital expects to increase the number of diabetic patients that optimally managed modifiable diabetes related risk factors by 10% in DY 5 over baseline. The baseline will be established in DY 3.

Starting Point/Baseline:

Currently, other than providing primary care and dietician consultations for diabetic patients, no formal diabetic education program exists. Reeves County Hospital District will utilize DY 2 to commence the development of a formal-credited diabetic education program. Additionally, as Reeves County Hospital District primarily serves Reeves County, this intervention will affect the citizens of Reeves County which consist of 13,757 residents as of 2011. Also, in 2011 the Pecos Valley Rural Health Clinic (owned and operated by Reeves County Hospital District) provided 15,962 total patient primary care visits.

This intervention will provide an education program to the estimated 10% of the adult population (approximately 1,376 citizens) of Reeves County that have been diagnosed with Type 1 or 2 diabetes.

Rationale:

This project addresses Community Need Identification numbers 1 and 2 as identified in the Community Needs Assessment. This project is a new initiative for Reeves County Hospital District.

Currently, other than providing primary care services, Reeves County Hospital District has no formal proactive program in place to prevent and reduce Hospital Admission related to poorly managed diabetes.

For this reason, in year two of the Waiver, Reeves County Hospital District selected Customizable Process Milestone P-X (Develop a Certified Diabetes Education Program). The Hospital District selected the customizable process milestone option, because no other process milestones within Category 2.2 clearly reflected the measures needed to achieve this objective. During this year, Reeves County Hospital District will work to create a diabetic education program with the goal of getting the program certified by the American Association of Diabetes Educators in year three of the Waiver.

In year three of the Waiver, the Hospital District selected Customizable Process Milestone P-X (Implement a Certified Diabetes Education Program). The Hospital District selected the customizable process milestone option, because no other process milestones within Category 2.2 clearly reflected the measures needed to allow for the implementation of the diabetes education program. Implementation will include the Hospital District successfully getting the diabetes education program certified by the American Association of Diabetes Educators, and the Hospital District commencing with the education program for the target population.

In order to measure success in years four and five of the Waiver, the Hospital District selected Improvement Milestone I-18: Improve the Percentage of Patients with Self-Management Goals by 5 and 10%. A major part of the Certified Diabetes Education Program will be to establish self-management goals for each patient that is enrolled in the program.

Lastly, each of the above measures selected will allow the Hospital District to move to a system that is currently reactive - responding mainly when a person is sick - to one that is proactive- focused on keeping a person as healthy as possible.

Relationship to Other Projects

Not Applicable

Related Category 3 Outcome:

In order to measure the effectiveness of the Reeves County Hospital District Diabetes Quality Enhancement Program and to take a further step in decreasing diabetic related complications under Category 3, Reeves County Hospital District has selected the following Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures. Our numerators for these measures will be the percent improvement in the targeted patient population over baseline.

Project Valuation

Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.
The Reeves County Hospital District- Diabetes Quality Enhancement Program received a ranking of 7 points out of the 24 possible points available. As a result for each year under the waiver 29% (7/24 =.29 or 29%) of Category 2 available funds will be allocated to the Diabetes Quality Enhancement Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure in that given year.

Milestones and Metrics Table

Unique Category 2 Project Identifier, 112684904.2.1	*RHP PP Reference Number: 2.2.2*	*Project Components: 2.2.2*	*Reeves County Hospital District Diabetes Quality Enhancement Program*
Reeves County Hospital District		*112684904*	
Related Category 3 Outcome Measure (s):	*112684904.3.1* *112684904.3.2* *112684904.3.3*	*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)**
Process Milestone 1 [P-X]: Develop a Certified Diabetes Education Program **Metric 1[P-X.1]:** Documentation of Diabetes Education Program **Data Source:** Program Materials and documentation needed to support certification process **Process Milestone 1: Estimated Incentive Payment (maximum amount):** $230,894	**Process Milestone 2 [P-X]:** Implement Certified Diabetes Education Program **Metric 1[P-X.1]:** Establish a certified diabetes education program through the American Association of Diabetes Educators. This includes the hiring or training of a certified diabetes educator **Data Source:** Documentation to support certification and HR records **Process Milestone 2: Estimated Incentive Payment (maximum amount):** $252,768	**Improvement Milestone 1 [I-18]:** Improve the percentage of patients with self-management goals by 5% over DY3 Baseline **Metric 1 [I-18.1]:** Patients with self-management goals **Numerator:** The number of patients with diabetes with at least one recorded management goal **Denominator:** Total number of patients with diabetes in registry **Data Source:** Registry **Improvement Milestone 1 Estimated Incentive Payment (maximum amount):** $254,496	**Improvement Milestone 2 [I-18]:** Improve the percentage of patients with self-management goals by 10% over DY3 baseline **Metric 2 [I-18.1]:** Patients with self-management goals **Numerator:** The number of patients with diabetes with at least one recorded management goal **Denominator:** Total number of patients with diabetes in registry **Data Source:** Registry **Improvement Milestone 2 Estimated Incentive Payment (maximum amount):** $231,675

Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $230,894	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $252,768	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $254,496	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $231,675
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $969,833			

Identifying Project and Provider Information:
Project Title and Option: Reeves County Hospital District Cancer Prevention Program, Category 2.7.1 Implement Evidence-Based Health Promotion and Disease Prevention Program,
Unique Identifier: 112684904.2.2
Performing Provider: Reeves County Hospital District/TPI: 112684904

Summary Information:
Provider: Reeves County Hospital District is a 25 bed-critical access Hospital located in Pecos, TX. Reeves County Hospital District provides health care services primarily to the citizens of Reeves County and several adjacent West Texas communities located in the counties of Ward, Culberson, Jeff Davis, and Presidio.

Intervention: This project will implement mammography services in order to provide breast cancer pre-screening, primarily to the citizens of Reeves County and adjacent communities whom currently have limited access, to improve the outcomes of those diagnosed with early stages of breast cancer.

Need for Project: Currently, in Region 14, 35% of women 40 years and older have not had a mammogram in the past two years. Moreover, women in Reeves County and surrounding adjacent communities would have to travel approximately a total of 154 miles to the closest provider of mammography services.

Relationship to RHP 14 Goals

In Region 14 twenty-six percent of adults 25 years or older did not graduate from high school. About 28% have some kind of college degree. Eighteen percent of all people in the RHP fall below the poverty line. Those with lower levels of education and income are less likely than adults with higher education and income levels to receive most of these preventative services.

In addition to the Reeves County Hospital District Cancer Prevention Project, several of the other providers within RHP 14 that are taking part in the DSRIP initiative have projects focused on increasing mammogram screenings. The other projects that are being conducted throughout the Region are as followed: Medical Center (Ector County) [135235306.2.7], Odessa Regional (Ector County) [112711003.3.7] and TTUHSC (081939301.1.4). Hopefully, with such a focused effort our Region will be successful at increasing the number of women whom receive annual mammograms and ultimately increase the Region's survival rate for women diagnosed with breast cancer. Lastly, RHP 14 has established a high rate of cancer as its community need number one and low utilization of preventive services as its community need number five.

Target Population: The target population for the Reeves County Hospital District Cancer Prevention Program will be all patients who utilize the Pecos Valley Rural Health Clinic that meet the age criteria to receive preventative cancer screenings for breast, colon and cervical cancers. In 2011 the Pecos Valley Rural Health Clinic (owned and operated by Reeves County

Hospital District) provided primary care services for a total of 15,962 patients. Of this 1,254 female patients were 40 years of age and above whom qualify for an annual mammogram, 1,622 female patients were 18 years of age and above whom qualify for a biennial pap smear, and 1,460 patients were over the age 50 whom qualify for a Fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. This includes the percentage of Medicaid patients within the region estimated at 15% or 2,394 total patients and those considered indigent estimated at .88% or 140 total patients for 2011.

Category 1 or 2 expected patient benefits:

The project seeks to implement the needed infrastructure required to provide mammogram services and to raise awareness in the areas of breast cancer, colon cancer, and cervical cancer screenings. This shall enable future improvement in the percentage of patients within the target population that receive screenings for breast, colon and cervical cancer by DY 4 and DY 5 in Category 3. In addition, this will have the ultimate effect of providing the target population the benefit of early cancer detection which is an important factor in increasing cancer survival rates.

Category 3 expected patient benefits:

Ultimately, the Hospital's goal is to increase the number of patients that receive cancer pre-screening services within the Hospital's target population.

CQI Element: Reeves County Hospital District will utilize its internal CQI infrastructure and reporting processes to track the effectiveness of the Cancer Awareness Program the Hospital has selected to create and implement by DY 3. After the program is implemented, the Hospital will utilize the methods of rapid cycle improvement to make and track the effectiveness of changes made to the program. Results will be reported quarterly.

Project Description:

Through the opportunity provided by the 1115B, Reeves County Hospital District would like to move from a focus on sickness and disease to one based on wellness and prevention. As noted in the Appendix of the Regional Healthcare Partnership 14 Community Needs Assessment on Table S page 19; 35% of women 40 years and older have not had a mammogram in the past two years, and 29% of women 18 years and older have had no pap smear within the last three years, 84% of men and women 50 years and older have had no Fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. As it relates to the percentage of these services provided to the population as a whole, the Region is currently performing worse than both the Federal and State averages. Currently, out of the three type of preventive services identified above Reeves County Hospital District does not provide mammogram services. In 2011 the Pecos Valley Rural Health Clinic (owned and operated by Reeves County Hospital District) provided primary care services for 1,254 female patients 40 years of age and above. Each of one those women qualify to receive annual mammography screenings as recommended by the American Cancer Society. However, in order to obtain a

mammography screening each of those women would have to travel on average a round trip of 154 miles to the closet provider of mammography services.

For the reasons stated above, as a major part of the Reeves County Hospital District Cancer Prevention Program, the Hospital District will commence in a project to implement a mammography program in order to increase mammography screenings in the Hospital's geographic service area.

Additionally, the other focus of the Reeves County Hospital District Cancer Prevention Program will include increasing awareness by creating and implementing a Cancer Awareness Program in year three, four and five of the 1115B Waiver. The focus of the program will be to encourage the targeted population to have regular cancer screenings provided by the Hospital District through provider interaction, through literature provided via Hospital's web site and through community events.

5 Year Expected Outcome

At the end of five years Reeves County Hospitals District ultimately expects to increase the number of patients within the target population that receive preventive pre-cancer screenings whom utilize the Pecos Valley Rural Health Clinic.

Starting Point/Baseline:

Currently, Reeves County Hospital District provides fecal occult blood test year, colonoscopies, and pap smears. Conversely, the Hospital District does not provide mammogram services. For this reason, the Hospital District will utilize Year Two of the waiver to take on the development of mammogram program.

Additionally, no reliable data exist on the total percentage of the targeted population that receives fecal occult blood test year, colonoscopies, mammograms, pap smears. For this reason Reeves County Hospital District will also utilize Year Two of the Waiver to develop and test data system for the collection of relevant data for the purposes of future performance improvement.

Lastly, in Year three of the Waiver, in order to increase patient awareness on the importance of cancer screening and ultimately increase the number of people that receive cancer screenings the Hospital District will commence the development of a cancer screening awareness program.

Rationale:

This project will help to meet Community Need Identification numbers 1, 5 and 6 as identified in the RHP 14 Community Needs Assessment. This project is a new initiative for Reeves County Hospital District.

As Reeves County Hospital District currently does not provide mammogram services, the Hospital District will utilize years two and three of the waiver to develop, plan and implement a mammography program. Additionally, the Hospital District selected the customizable process and improvement milestone options to create and implement a cancer awareness program in years three, four and five of the waiver. The Hospital District selected the customizable process and improvement milestone options because no other milestones reflected the needed metrics and measures to implement the cancer awareness component.

By concentrating on the prevention of chronic disease, the community moves from a focus on sickness and disease to one based on wellness and prevention.

Relationship to other Projects:
Not Applicable

Related Category 3 Outcome:
Currently, no data exist on the percentage of patients Reeves County Hospital District provides service to that receive colon, breast, and cervical cancer screenings. For this reason Reeves County Hospital District has selected P-3 Develop and Test Data Systems and P-2 Establish baseline rates as its process measures for year two and three under Category Three. In order to measure performance, the Hospital District in years four and five has selected OD 12 Primary Care and Prevention as its Category 3 outcome measures.

Project Valuation
Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District- Cancer Prevention Program received a ranking of 11 points out of the 24 possible points available. As a result for each year under the waiver 46% (11/24 =.46 or 46 %) of Category 2 available funds will be allocated to the Cancer Prevention Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure in that given year.

Milestones and Metrics Table

UNIQUE CATEGORY 2 PROJECT IDENTIFIER, 112684904.2.2	*RHP PP REFERENCE NUMBER: 2.7.1*	*PROJECT COMPONENTS: 2.7.1*	*REEVES COUNTY HOSPITAL DISTRICT CANCER PREVENTION PROGRAM*
REEVES COUNTY HOSPITAL DISTRICT		*112684904*	
RELATED CATEGORY 3 OUTCOME MEASURE (S):	*112684904.3.4* *112684904.3.5* *112684904.3.6*	*IT.12.1* *IT.12.2* *IT.12.3*	*BREAST CANCER SCREENING* *CERVICAL CANCER SCREENING* *COLORECTAL CANCER SCREENING*
Year 2 (10/1/2012 – 9/30/2013)	**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]: Development of innovative evidence based project for targeted population **Metric 1[P-1.1]:** Document innovational strategy and plan **Data Source:** Reeves County Hospital District strategy and plan. **Process Milestone 1: Estimated Incentive Payment (maximum amount):** $366,246	**Process Milestone 2 [P-2]:** Implement evidence-based innovational project for targeted population **Metric 1 [P-2.1]:** Document implementation strategy **Data Source:** Reeves County Hospital District Board Minutes, Mammography Machine Contract, Mammography Technician Employment Records **Process Milestone 2 Estimated Incentive Payment (maximum amount):** $200,471 **Process Milestone 3 [P-X]:** Develop a cancer screening awareness program	**Improvement Milestone 1 [I-X]:** Deploy Cancer Awareness Program **Metric 1 [I-X.1]:** Increase the target population's knowledge and awareness of cancer pre-screenings services Baseline/goal: Conduct two community events a year centered around increasing the communities knowledge of cancer awareness **Data Source:** Documentation to support delivery of awareness program **Improvement Milestone 1 Estimated Incentive Payment (maximum amount):** $403,684	**Improvement Milestone 2 [I-X]:** Deploy Cancer Awareness Program **Metric 1 [I-X.1]:** Increase the target population's knowledge and awareness of cancer pre-screenings services Baseline/goal: Conduct two community events a year centered around increasing the communities knowledge of cancer awareness **Data Source:** Documentation to support delivery of awareness program **Improvement Milestone 2 Estimated Incentive Payment (maximum amount):** $367,484

	Metric 1[P-X.1]: % Document awareness program. **Data Source:** Awareness Program Materials **Process Milestone 3 Estimated Incentive Payment (maximum amount):** $200,471		
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $366,246	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $400,942	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $403,684	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $367,484
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $1,538,356			

Identifying Project and Provider Information:
Project Title/Option: Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative Category 2.4.3, Redesign to Improve Patient Experience
Unique Identifier: 112684904.2.3
Performing Provider: Reeves County Hospital District/TPI: 112684904

Summary Information
Provider: Reeves County Hospital District is a 25 bed-critical access Hospital located in Pecos, TX. Reeves County Hospital District provides health care services primarily to the citizens of Reeves County and several adjacent West Texas communities located in the counties of Ward, Culberson, Jeff Davis, and Presidio.

Intervention: This project will implement patient satisfaction surveys for the Pecos Valley Rural Health Clinic to increase overall patient satisfaction.

Need for Project: Currently, Reeves County Hospital District has no formal method for measuring patient satisfaction for the Pecos Valley Rural Health Clinic.

Relationship to RHP 14 Goals

RHP 14 has established overcoming barriers to care as its community need number six. In addition to the Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative, several of the other providers within RHP 14 that are taking part in the DSRIP initiative have projects focused on improving patient satisfaction. The other projects that are being conducted throughout the Region are as followed: Medical Center (Ector County) [135235306.3.4], Odessa Regional (Ector County) [112711003.3.1], Scenic Mountain Medical Center (Howard County) [130725806.3.2], Permian Basin Community Centers (Ector County) [138364812.3.1] and TTUHSC [081939301.1.2].

Target Population: The target population for improving overall patient satisfaction in the Reeves County Hospital District Patient Experience Improvement Initiative will be all patients whom utilize the Pecos Valley Rural Health Clinic. In 2011 this consisted of 15,962 patients. This includes the percentage of Medicaid patients within the region estimated at 15% or 2,394 total patients and those considered indigent estimated at .88% or 140 total patients for 2011. The Hospital has set a goal of completing 400 patient CAHPS survey per year.

Category 1 or 2 expected patient benefits:
The ultimate goal of Reeves County Hospital District Patient Experience Improvement Initiative under category 2 is to establish the needed infrastructure for future improvement in patient satisfaction to take place in DY 4 and DY 5 in Category 3. This will have the effect of involving patients in their health care decision making, make the providers within the Pecos Valley Rural Health Care Clinic more accountable and will increase the overall quality of care.

Category 3 expected patient benefits:

The ultimate goal of the Reeves County Hospital District Patient Experience Improvement Initiative under category 3 is to increase overall patient satisfaction for those patients within the target population over baseline in DY 4 and DY 5.

Project Description:

In the Regional Healthcare Partnership 14 Community Needs Assessment Appendix on page 13 in Table K, according to the Center for Health Statistics, Reeves County Texas had a physician per county population rate of 73.7. In Region 14, Reeves County Hospital District is the top performer in the Region as it relates to this specific ranking. Additionally, we exceed the State Average rate of 69.5 in 2011. In 2011, the Pecos Valley Rural Health Clinic (owned and operated by Reeves County Hospital District) also provided 15,962 total patient primary care visits primarily to the citizens of Reeves County. Based on this data, Reeves County Hospital District is currently meeting the primary health care needs of the community it serves. However, in order to maintain this standard the Hospital must now shift our focus on the quality of healthcare delivery the Pecos Valley Rural Health Clinic is providing as measured by the patients it serves.

For this reason under the 1115B Waiver, Reeves County Hospital District will commence in a project to improve the patient experience for all patients served by the Pecos Valley Rural Health Clinic through customer satisfaction surveys with the ultimate goal of increasing overall patient satisfaction.

5 Year Expected Outcome

At the end of five years Reeves County Hospitals District ultimately expects to increase the level of patients' satisfaction among the patients whom utilize the Pecos Valley Rural Health Clinic.

Starting Point/Baseline:

Currently, no formal data or baseline exists on patient satisfaction for the Pecos Valley Rural Health Clinic. Reeves County Hospitals District will utilize Year 2 of the waiver to commence Patient Surveys to establish a baseline.

Additionally, as the Pecos Valley Rural Health Clinic primarily serves Reeves County, this intervention will affect the citizens of Reeves County which consist of 13,757 residents as of 2011. Also, in 2011 the Pecos Valley Rural Health Clinic provided 15,962 total patient primary care visits. The baseline data in Year 2 of the waiver will be taken from the total patients the Pecos Valley Rural Health Clinic serves starting October 1 of 2012.

Rationale:

This project addresses Community Need Identification number-6 of enhancing overall patient experience as identified in the RHP 14 Community Needs Assessment. This project is a new initiative for Reeves County Hospital District.

Reeves County Hospital District has been successfully within the past 5 years at recruiting and maintaining and adequate supply of primary care providers that serve Reeves County and the surround geographical areas. This statement is supported by the Regional

Healthcare Partnership 14 Community Needs Assessment Appendix on page 13 in Table K. If Reeves County Hospital District is going to maintain this level of service we need to employ measures to monitor, report, and improve on the Patient Satisfaction for the citizens we serve. However, currently there is no formal method in place for reporting patient satisfaction for the Pecos Valley Rural Health Clinic. For this reason under the 1115B waiver we have identified Category 2.4 Redesign to Improve Patient Experience as a noteworthy project. Over time, this project has the potential to yield improvement in the level of care integration and coordination for patients, and ultimately lead to better health and better patient experience of care.

The following explains each milestone and metric the Hospital District has chosen each year of the waiver for the Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative along with and explanation for choosing each:

Year 2: P-1 Appoint and Executive Accountable for Experience Performance- This measure was selected to clearly delineate and delegate and individual responsible for the success of patient experience program.

P-10 Administer Regular Inquires into Patient Experience- As Reeves County Hospital currently does not administer patient experience survey for the Pecos Valley Rural Health Clinic this will be the starting point of the Patient Experience Improvement Initiative.

Year 3: P-3**:** Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. In order to truly impact overall patient satisfaction, it is important to capture a full perspective of any issues that exist may exist that hinder improvement. This includes individuals outside of the day to day operations.

P-7: Assess the organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement**.** It is important to clearly establish the organizational baseline as the foundation for future improvement work. This measure will be used in years four and five in order to re-establish the organization baseline for further improvement work.

P-11: Orchestrate improvement work on identified experience targets. In order to improve patient experience surveys in future years of the Waiver it is important to commence improvement work.

P-15: Develop a training program on patient experience. In order to truly impact overall patient satisfaction performance it is important enhance staff knowledge of how to improve patient satisfaction.

Year 4: I-19: Make patient experience data available externally. It is important that the Hospital involve the community by making satisfaction scores available externally in order to show accountability.

Relationship to other Projects:

Not Applicable

Related Category 3 Outcome:

In order to measure the effectiveness of the Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative under Category 3, Reeves County Hospital District has selected Stand Alone Measures OD6 IT.6.1 Percent Improvement over Baseline of Patient

Satisfaction as its outcome measures. Our numerator for this measure will be the percent improvement in the targeted patient satisfaction domain.

Project Valuation

Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District-Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative received a ranking of 6 points out of the 24 possible points available. As a result for each year under the waiver 25% (6/24 =.25 or 25%) of Category 2 available funds will be allocated to the Patient Experience Project. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure in that given year.

Milestones and Metrics Table

Unique Category 2 Project Identifier, 112684904.2.3	*RHP PP Reference Number: 2.4.3*	*Project Components: 2.4.3*	*Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative*
Reeves County Hospital District		*112684904*	
Related Category 3 Outcome Measure(s):	*112684904.3.7*	*IT.6.1*	*Patient Satisfaction, Percent Improvement Over Baseline of Patient Satisfactions 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)**
Process Milestone 1 [P-1]: Appoint and 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 **Data Source:** Job Description (or percentage of time) **Process Milestone 1: Estimated Incentive Payment (maximum amount):** $99,523 **Process Milestone 2[P-10]:** Administer regular inquiries into patient experience for the Pecos Valley Rural Health Clinic **Metric 1[P-10.1]:** % of active patients	**Process Milestone 3 [P-3]:** Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee will meet at least once a month. **Metric 1 [P-3.1]:** Documentation of committee proceedings and list of committee Members **Data Source:** Meeting minutes, agendas, participant lists, and/or list of steering committee members **Process Milestone 3 Estimated Incentive Payment (maximum amount):** $54,476 **Process Milestone 4 [P-7]:**	**Improvement Milestone 1 [I-19]:** Make patient experience data available externally (e.g., via the Hospital's external website) to provide updates to the general public on the efforts the organization is undertaking to improve the experience of its patients and their families **Metric 1 [I-19.1]:** Posting of external communications aimed at the general public understands of the organization's results and improvement efforts in the area of patient and/or employee experience. **Data Source:** Documentation of External communication material used **Improvement Milestone 1 Estimated**	**Improvement Milestone 2 [I-19]:** Make patient experience data available externally (e.g., via the Hospital's external website) to provide updates to the general public on the efforts the organization is undertaking to improve the experience of its patients and their families **Metric 1 [I-19.1]:** Posting of external communications aimed at the general public understands of the organization's results and improvement efforts in the area of patient and/or employee experience. **Data Source:** Documentation of External communication material used **Improvement Milestone 2 Estimated**

who were included in and inquiry **Numerator:** number of patient inquires made **Denominator:** Number of patient visits during the measurement time period **Data Source:** Data from HCAPS surveyor and data from Hospital Clinic stats. **Process Milestone 2: Estimated Incentive Payment (maximum amount):** $99,523	Assess the 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 the following questions: 1.What is the scores/findings for the organization as a whole? 2.What are the scores/findings by provider, location, and patient demographics?; 3. What are the response rates by service line, and patient demographics?; **Data Source:** Assessment **Process Milestone 4 Estimated Incentive Payment (maximum amount):** $54,476 **Process Milestone 5 [P-11]:** Milestone: Orchestrate improvement work on identified experience targets (targets could include, for example, better understanding of HCAHPS results or results of other measures; improved caregiver communication; better discharge planning; improved cleanliness; better ambulatory experience; etc.). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup.	**Incentive Payment (maximum amount):** $109,697 **Process Milestone 7 [P-7]:** Assess the 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 the following questions: 1.What is the scores/findings for the organization as a whole? 2.What are the scores/findings by provider, location, and patient demographics?; 3. What are the response rates by service line, and patient demographics?; **Data Source:** Assessment **Process Milestone 7 Estimated Incentive Payment (maximum amount):** $109,697	**Incentive Payment (maximum amount):** $99,860 **Process Milestone 8 [P-7]:** Assess the 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 the following questions: 1.What is the scores/findings for the organization as a whole? 2.What are the scores/findings by provider, location, and patient demographics?; 3. What are the response rates by service line, and patient demographics?; **Data Source:** Assessment **Process Milestone 8 Estimated Incentive Payment (maximum amount):** $99,860

	Metric 1[P-11.1]: Submission of implementation plan. **Data Source:** Documentation to support Implementation plan **Process Milestone 5 Estimated Incentive Payment (maximum amount):** $ 54,476 **Process Milestone 6 [P-15]:** Develop a training program on patient experience **Metric 1[P-15.1]:** Submission of training program materials **Data Source:** Training Materials **Process Milestone 6 Estimated Incentive Payment (maximum amount):** $ 54,476		
Year 2 Estimated Milestone Bundle Amount: (add amounts from each milestone and metric): $199,046	Year 3 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $ 217,904	Year 4 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $ 219,394	Year 5 Estimated Milestone Bundle Amount (add amounts from each milestone and metric): $199,720
Total Estimated DSRIP Funding for 4 Years (add amounts of Estimated DSRIP Funding for years 2-5): $836,064			

Identifying Information:
Project/Intervention Title: West Texas Centers & Scenic Mountain Medical Center Co-Location/Integration Project
Project Number: 130725806.2.1
Performing Provider: West Texas Centers
TPI: 130725806

Summary Information:

Provider: West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health and intellectual and developmental disabilities for the established service area. The Center began operations on March 1, 1997 and continues to serve as the designated local authority for mental health and intellectual and developmental disabilities through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in ten counties in the RHP 12 area. WTC offers a wide array of mental health services to include 24 hour crisis intervention, case management, psychiatric evaluation and consultation, medication management, supported housing and employment and psychiatric rehabilitation.

Intervention: This is an integration project between a primary care provider, Scenic Mountain Medical Center (SMMC) and WTC in Big Spring, Texas. WTC currently operates a mental health clinic in Big Spring employing about sixty staff on site and several remote providers doing telemedicine services. This integration will involve WTC moving to a co-located site with SMMC and a gradual collaboration to include cross training, consultation and sharing of space and potentially administrative support staff, nursing and other clinical staff. This endeavor is the first of its kind for West Texas Centers as well as for Big Spring and Howard County and will provide a level of care not normally present in such a rural area. It will provide the groundwork for West Texas Centers to develop similar levels of integration through its other service areas as funding and opportunities may arise.

Need for the Project: West Texas Centers currently serves an average of 856 persons per month in the RHP area, with approximately four hundred and twenty-five of those residing in Big Spring and Howard County. As there is a limited number of primary care providers in Howard County it is almost a certainty that virtually all these persons either do not have a primary care provider or see one of those currently practicing in the county. In an area with little public transportation and an ongoing shortage of all types of providers an integration of primary and behavioral health care will improve access to both types of services by the full population of the County.

Target Population: West Texas Centers currently serves a monthly average of 44% persons with Medicaid and 54% indigent in Howard County. It is estimated this percentage will be similar through the project.

Category 2 expected patient benefits: West Texas Centers currently provides physicians behavioral health care services to approximately 425 persons in Howard County. It is expected by DY 4, 72 of those persons will be receiving care at the new location utilizing this projects integrated health care processes and model to include treatment plans developed and implemented with primary and behavioral health care expertise. This number will increase to 144 patients in DY 5. These patient numbers are minimum targets. There is probability as integrated services and processes become more normal patients will move quicker into the integrated model.

Category 3 outcomes: West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement measure IT-6-1: Percent Improvement over baseline of patient satisfaction scores with standalone measure (1) patients are getting timely care, appointments, and information. During DY3, the process measure to develop and test systems will include selection of the patient satisfaction survey instrument and actual conducting of the baseline survey. DY 4 and DY5 will require 25% and 40% improvement respectively in the improvement measure as measured by the patient satisfaction survey instrument.

Project Description:

West Texas Centers will develop a behavioral health and primary care integrated project in Howard County, Big Spring, Texas. Co-location will occur through a lease arrangement with Scenic Mountain Medical Center (SMMC). SMMC is a private hospital also operating a primary care clinic at 1601 W. 11th Place. West Texas Centers will occupy space in the primary care clinic with direct access to the SMMC hospital and their emergency department. Howard County is a designated Health Professional Shortage Area (HPSA), with a very rural population of approximately 31,000. SMMC is the only hospital in a forty-five mile radius. West Texas Centers operates the only outpatient Mental Health clinic in the community. The project will provide onsite access to behavioral health care while facilitating more opportunities to address both the physical and mental needs of the consumer. Current integration with primary health care is limited to “crisis events” and limited coordination with PCP providers when patient needs overlap. Diversion from the emergency department and from potential incarceration/law enforcement involvement should occur more naturally and more effectively through the co-location arrangement. Through the integration of behavioral health and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Howard County has limited public transportation. This project will enhance access to care as individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs. Given the ever-increasing cost of transportation, a “one stop shopping” approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions. Research supports co-location alone is not synonymous with

integration. Levels of interaction between physical and behavioral health providers may range from traditional minimally collaborative models to fully integrated collaborative models. This project will result in behavioral health providers sharing the same facility, having some systems in common, participating in regular face-to-face communication and functioning with primary care providers in team approaches to patient care. This will be the first such integration project in the community related to behavioral health and primary care.

Expected challenges will involve the continued difficulty rural providers have in recruiting and retaining qualified professional staff. Additionally, the rural nature of the community and lack of any public transportation will continue to present significant difficulties for consumers. As with any integration of historically separate systems, staff and consumer's resistance to change will require processes to be well communicated and carefully implemented. WTC's excellent community relationships and already established community partners should provide an effective basis to meet these challenges.

The expected outcome by the end of demonstration year 5 is to have developed a close collaboration environment in a co-housed facility with Scenic Mountain Medical Center. The project will result in behavioral health and primary care provider's interacting in regular face-to-face communication, identifying training needs, providing a "pool" of professionals with differing expertise while addressing multiple needs of the consumer. Other expected outcomes include increased diversion from the emergency department of the local hospital, better coordination of shared patients primary and behavioral care appointment scheduling, thus reducing some transportation needs and increased community behavioral health education opportunities. Specific improvement targets, as discussed in the valuation section of this document, will see a minimum of 72 individuals will be served under the integrated care model receiving both primary and behavioral health care services to include collaboration between behavioral health and primary care providers in development of patient treatment plans. In DY 5 it is projected this number will increase to a minimum of 144 patients.

Continuous Quality Improvement:

West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution.

Starting Point/Baseline:

Baseline encounter data will be obtained from WTC fiscal year 2012 records to include unduplicated monthly Howard County mental health consumers served as well as other data relevant to this project. Goal determination was based upon the full relocation of the Howard County Mental Health clinic and a percentage of that current population being served through the integrated care model. Howard County Mental Health clinic currently serves a low income/indigent population of approximately 425 persons. WTC will continue to identify and refine baseline data during DY 2 as WTC currently has no co-located facility serving both behavioral health and primary care.

Rationale:

This project addresses RHP 14 Community Needs Assessment number CN1-Access to Primary Care, CN3-Access to Specialty Care, CN4-Access to Mental Health Providers and CN19-Enhance Overall Patient Experience. This project represents a new initiative for West Texas Centers as well as the RHP. Howard County currently has providers in separate facilities with only limited interaction. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking g and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied. The integration of behavioral health and primary care logically improve the opportunities to better meet the needs of the consumer while lowering costs through economies of scale. An integrated model will also demonstrate a progressive, evidenced based approach to health care essential to the recruitment and retention of highly qualified professionals, particularly in rural communities. The importance of this project to the local community in Howard County cannot be overstated. West Texas Centers will complete all core components of this project. Those components are: a) identify sites for integrated care projects, which would have the potential to benefit a significant number of parties in the community; b) develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated; c) establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers; d)recruit a number of specialty providers(physical health, mental health, substance abuse, etc. to provide services in the specified locations; e) train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include; regular consultative meetings between physical health and behavioral health practitioners; case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or shared treatment plans co-developed by both physical health and behavioral health practitioners; f) acquire data reporting, communication and collection tools(equipment) to be used in the integrated setting, which may include an integrated EHR record system or participation in a health information exchange; g) explore the need for and develop any necessary legal agreement that may be needed in a collaborative practice; h) arrange for utilities and building services for these settings; i) develop and implement data collection and reporting mechanisms and standards to track utilization of integrated services as well as the health care outcomes of individuals treated in these integrated service settings; j) conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to identifying project impacts, identifying lesions learned, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. West Texas Centers has thoroughly reviewed these core components and developed strategies associated with each. Strategies include utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid

address of deficiencies and problem resolution is occurring. West Texas Centers recognizes the importance of achieving all required core components of this project and anticipates all components, milestones and metrics will be achieved within the 5 year demonstration period.

Related Category 3 Outcome Measure(s):

West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems was selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures.

West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This expectation was increased to 40% in DY 5. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

Relationship to other Projects:

This project relates significantly to West Texas Centers Project Number 1307258061.11.1 expansion of telemedicine services project. This project anticipates utilization of telemedicine in the delivery of services as well as between providers of primary care and behavioral health services.

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

Plan for Learning Collaborative*:*

RHP 14 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaboratives would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

Project Valuation:

Currently West Texas Centers does not operate a co-located site with a primary care provider or a hospital. Scenic Mountain Medical Center has indicated there is a potential to lease co-located space in their physicians clinic at 1601 W 11th Place. They or their landlord would do the extensive remodeling required to meet our needs and West Texas Centers would relocate its Howard County Mental Health Clinic to that location. This would result in co-location with four to six primary care and specialty physicians and hallway access the SMMC's hospital and emergency department. West Texas Centers will increase access to psychiatric

services through the increase of psychiatric contracts and recruitment of additional psychiatrists, nursing staff and administrative support staff. The location will provide ready access to SMMC's emergency department by West Texas Center crisis outreach staff to provide behavioral health expertise prior to admission decisions. Extensive research has been done related to the patient experience, the cost effectiveness and the overall benefits to integration of behavioral and primary health care in America. Research indicates some of the benefits achieved through integrated service delivery include; improved recognition of mental health and physical health disorders, improved PCP and behavioral health provider's skills in medication prescription practices[1], increased PCP and behavioral health provider confidence in service delivery[2]. Co-location and service integration present increased opportunities for economies of scale in the delivery of patient services, to include collaboration of providers, more effective utilization of provider specialties, optimization of billing and reimbursement activities in addition to the more effective treatment of the patient as a whole.[33] West Texas Centers also considered reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

It is anticipated by DY 4 and 5 West Texas Centers will be providing its entire Howard County physician and associated clinical support services at the new integrated location. Currently West Texas Centers provides these services to approximately 425 low income/indigent consumers. Of this population by DY 4 a minimum of 72 individuals will be served under the integrated care model receiving both primary and behavioral health care services to include collaboration between behavioral health and primary care providers in development of patient treatment plans. In DY 5 it is projected this number will increase to a minimum of 144 patients. It is expected the model will accommodate additional persons as ongoing process and service improvements occur which could potentially increase these projections substantially; however since there is currently no similar behavioral health and primary health care integration occurring in this county it is difficult to identify exact patient transition and timeframes from the current model.

[1]Katon et.al. 1990
[2]Robinson et.al. 2009
[3]Mental Health America; Position Statement 13: Integration of Mental and General Health Care June 9, 2012

130725806.2.1	2.1	2.15.1 COMPONENTS A,B,C,D,E,F,G,H,I,J	West Texas Centers Scenic Mountain Medical Center Co-Location/Integration Project
West Texas Centers			130725806
Related Category 3 Outcome Measure(s)	130725806.3.2	OD-6.1	Patient Satisfaction

Year 2	Year 3	Year 4	Year 5
Process Milestone 1 [P-X]: Complete lease arrangements for co-location/integration to include floor plan remodeling design and completion timeframes. Metric 1 [P-X.1]: Signed lease agreements and other related facility use agreements with Scenic Mountain Medical Center or their landlord at the proposed integration site. Data Source: Project data, lease documents, etc Baseline: Currently there is no co-location arrangement between West Texas Centers and Scenic Mountain Medical Center therefore baseline for this milestone is N/A. Goal: To complete all necessary agreements at co-location/integration site to facilitate relocation of West Texas Centers Howard County Mental Health Clinic to the new integrated location in DY 3.	Process Milestone 2 [P-X]: Relocate Howard County Mental Health Clinic to integrated site at 1601 11th Place. Metric 1 [P-X.1]: Change in address to integrated site for Howard County Mental Health Clinic Data Source: Project data, mailing address, payroll information Baseline: Current address for Howard County Mental Health Clinic is 319 Runnels, Big Spring, Texas Goal: Relocation of Howard County Mental Health Clinic to SMMC location at 1601 W 11th Place, Big Spring, Texas Process Milestone 2 Estimated Incentive Payment $398,283.50 Process Milestone 3 [P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health	Improvement Milestone 1 [I-8]: Integrated Services Metric 1 [I-8.1]: 10% of individuals receiving both physical and behavioral health care at the established location. Numerator: Number of individuals receiving both physical health and behavioral health in the project sites. Denominator: Number of individuals receiving services in project sites. Data Source: Project data; claims and encounter data; medical records, patient census Baseline: Howard County WTC patient census DY 3. Goal: A minimum of 72 individuals receiving physician services from West Texas Centers Howard County active patient census will receive both physical and behavioral health care at the WTC integrated care location.	Improvement Milestone 3 [I-8]: Integrated Services Metric 1 [I-8.1]: 20% of individuals receiving both physical and behavioral health care at the established location. Numerator: Number of individuals receiving both physical health and behavioral health in the project sites. Denominator: Number of individuals receiving services in project sites. Data Source: Project data; claims and encounter data; medical records, patient census Baseline: Howard County WTC patient census DY 3. Goal: A minimum of 144 individuals receiving physician services from West Texas Centers Howard County active patient census will receive both physical and behavioral health care at the WTC integrated care location. Improvement Milestone 3 Estimated

Process Milestone 1 Estimated Incentive Payment: $762,874.00	providers and vice versa. Metric 1 [P.3.1]: Number and types of referrals that are made between providers at the location. Metric 2 [P.3.2]: Number of referrals that are made outside the location Metric 3 [P.3.3]: Number of referrals which follow the established standards Data Sources for P.3.1, 3.2 and 3.3: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results. Baseline: No current baseline data available Goal: establish reliable data collection systems to determine baseline for identification of continuous improvement targets Category 3 for DY 4 and 5. Process Milestone 3 Estimated Incentive Payment: $398,283.50	Improvement Milestone 1 Estimated Incentive Payment: $426,064.50 Improvement Milestone 2 [I-9] : Coordination of Care Metric 1 [I-9.1]: 10% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Numerator: Number of individuals with treatment plans developed and implemented with primary care and behavioral health expertise. Denominator: Number of individuals receiving services at project sites. Baseline: WTC Howard County active caseload census and EHR patient records end of DY 3. Goal: A minimum of 72 WTC patients receiving behavioral health physician services will have treatment plans developed and implemented with primary care and behavioral expertise indicated. Data Source: Project data; claims and encounter data; medical records Improvement Milestone 2	Incentive Payment : $411,710.50 Improvement Milestone 4 [1-9]: Coordination of Care Metric 1 [I-9.1]: 20% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Numerator: Number of individuals with treatment plans developed and implemented with primary care and behavioral health expertise. Denominator: Number of individuals receiving services at project sites. Baseline: WTC Howard County active caseload census and EHR patient records end of DY 3. Goal: A minimum of 144 WTC patients receiving behavioral health physician services will have treatment plans developed and implemented with primary care and behavioral expertise indicated. Data Source: Project data; claims and encounter data; medical records Improvement Milestone 4 Estimated Incentive Payment: $411,710.50

		Estimated Incentive Payment: $426,064.50	
Year 2 Estimated Milestone Bundle Amount: $762,874	Year 3 Estimated Milestone Bundle Amount: $796,567	Year 4 Estimated Milestone Bundle Amount: $852,129	Year 5 Estimated Milestone Bundle Amount: $823,421
Total Estimated Incentive Payments for 4-Year Period: $ 3,234,991			

E. Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

Outcome Measure: IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*[29]

Unique Category 3 Identifier: 135235306.3.1

Performing Provider: Medical Center Health System TPI: 135235306

Outcome Measure Description:

Diabetes HbA1c measure is designed to measure the percentage of patients aged 18 through 75 years with type 1 or type 2 diabetes mellitus that had a most recent hemoglobin A1c (HbA1c) greater than 9 percent. Identifying HbA1c values greater than 9 percent among adult patients aged 18 to75 years allow an organization the opportunity to focus on those patients who are in poor control and at highest risk.

As with all performance measures, there are essential inclusions, exclusions, and clarifications that are required to ensure that an organization collects and reports data in the same way. This allows a health center using the measure to compare itself with others.

The importance of glycemic control as part of the comprehensive management of diabetes is well documented, and HbA1c testing is a well-established strategy to monitor glycemic control in patients with diabetes. Unfortunately, NCQA data from 2007(6) reveals that between 13 and 22 percent of patients with diabetes do not get regular HbA1c testing. When tested, significant numbers of patients are in poor control with HbA1c values of 9 percent or greater: 29.6 percent of commercial populations, 27.3 percent for Medicare, and 48.7 percent of Medicaid populations. Systematic approaches are necessary to achieve improvements in the quality of care delivery and health care outcomes for patients.

Putting systems in place to track HbA1c testing frequency and HbA1c values enables an organization to better understand how effectively it is able to care for its patients with diabetes. Identifying adult patients aged 18 through 75 years with HbA1c values greater than 9 percent provides an opportunity for an organization to focus attention and services on those patients who are in poor control and at highest risk. These same tracking systems can facilitate appropriate management and follow-up for patients providing critical steps to help them attain and maintain their established glycemic goals.

After setting the initial base line, the clinic will reduce patients with HbA1c values by 10% by the end of the project.

---

29 http://www.htsrec.com/janda/pdf/2012EP_MeasureSpecifications/NQF%200059/NQF_HQMF_HumanReadable_0059.pdf

Rationale:

Diabetes is a chronic disease that is characterized by a broad range of metabolic abnormalities. Continued medical management and patient self-management are required to prevent acute complications and minimize the risk of complications that develop over time. Although diabetes medical management continues to improve, significant challenges remain. Consider the following:

- Diabetes is a leading cause of disability and death in the United States, affecting an estimated 17 million people – about 6.2 percent of the population. Approximately one-third are unaware of their disease.
- Each year, nearly one million American adults are diagnosed with diabetes.
- Total cost of diabetes in the United States is estimated at more than $98 billion annually.
- HbA1c measures blood glucose control in type 1 and type 2 diabetics. For every 1 percent reduction in results of HbA1c blood tests, the risk of developing eye, kidney, and nerve disease is reduced by 40 percent while the risk of heart attack is reduced by 14 percent.[3, 4]
- Diabetes disproportionately affects racial and ethnic minorities. African Americans, Hispanics, Native Americans, and Asian/Pacific Islanders are more likely to be diagnosed with diabetes. Rates of diabetic-related kidney failure are 2.6 times higher among African Americans. Death rates are also higher among African American, Hispanic, and Native American diabetics.[5]

Although the challenge is daunting, it is clear that experts do know what good diabetes care looks like and are continually increasing public knowledge about good diabetes care. The scientific literature, centers of excellence in diabetes care, and the experience of health care organizations are consistent in pointing to common themes in excellent diabetes care.

Outcome Measure Valuation:

In determining the value of this project, Medical Center analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.

The value of accomplishing the improvement target for this outcome domain is manifold: it will improve patient health outcomes, patient quality of life, patient functionality, and will reduce the short term and long terms costs of treating the consequences of uncontrolled HbA1c.

135235306.3.1	***3.IT 1.10***	***Diabetes care: HbA1c poor control (>9.0%)***	
Medical Center Health System 135235306			
Related Category 1 or 2 Projects	*135235306.1.1*		
Starting Point/Baseline	New project		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [**P-1**]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $250,370	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $145,106 **Process Milestone 2 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $145,105	**Outcome Improvement Target 1 [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%)** Improvement Target: Improve 5%. Data Source: Electronic Health Record of patients with HbA1c of 9 or above. Outcome Improvement Target 1 Estimated Incentive Payment*:* $475,688	**Outcome Improvement Target 2 [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%)** Improvement Target: Improve 10% Data Source: Electronic Health Record of patients with HbA1c of 9 or above. Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,113,601
Year 2 Estimated Outcome Amount: $250,370	Year 3 Estimated Outcome Amount: $290,211	Year 4 Estimated Outcome Amount: $475,688	Year 5 Estimated Outcome Amount: $1,113,601
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $2,129,870			

Identifying Outcome Measure and Provider Information:
Outcome Measure IT 3.11: Pediatric Asthma 30-Day readmission rate
Unique Category 3 Identifier: 135235306.3.2
Performing Provider: Medical Center Health System, 135235306

Outcome Measure Description:
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: Decrease the 30 Day Pediatric Asthma Readmission Rate by 10%
- DY5:
    - IT-3.1: Decrease the 30 Day Pediatric Asthma Readmission Rate by 15%

Rationale:

Process milestones – P-1, P-2, and P-3 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new project for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program, For DY3, we will be implementing the program, therefore several PDSA cycles will be needed in order to determine the best practices for this program moving forward. The baseline rate will be established during DY3 as the initial phases of the project are implemented.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 10% in DY4 and 15% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.
This measure was chosen to ensure that a common childhood affliction received the proper attention given its prevalence in this area. According to school district records, school nurses had 15,837 encounters with Asthmatic students. According to the American Academy of Allergy, Asthma & Immunology (AAAAI) about 1 in 10 children (10%) had asthma in 2009 with 3

out 5 having an asthma attack the previous year. According to the AAAAI, in 2008 less than half of people with asthma reported being taught how to avoid triggers, which further explains the rationale for targeting this disease state.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. We feel that the health system must adapt our practices to meet the needs of our community. Asthma is the top complaint and DRG in Ector County when it comes to pediatrics and therefore requires a substantial commitment from us to meet those needs. Given the Medicaid shortfalls in Texas, proper outpatient management can and will have a substantial impact on the not only local economies, but state as well. In addition, after speaking with the school district it is apparent that students missing school has a profound impact on their funding, so it becomes even more critical that we address this issue.

135235306.3.2	***3.IT 3.11***	***Pediatric Asthma 30-Day Readmission Rate***	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.1.2***		
Starting Point/Baseline	***Baseline will be established in DY3***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Planning Materials Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $249,128	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EHR, Performance Improvement Process Milestone 2 Estimated Incentive Payment: $298,772	**Outcome Improvement Target 1 [IT-3.11]:** Pediatric Asthma 30-Day Readmission Rate Improvement Target: 10% Reduction Data Source: EHR, Performance Improvement Outcome Improvement Target 1 Estimated Incentive Payment*:* $463,378	**Outcome Improvement Target 2 [IT-3.11]:** Pediatric Asthma 30-Day Readmission Rate Improvement Target: 15% Reduction Data Source: EHR, Performance Improvement Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,108,078
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $249,128	Year 3 Estimated Outcome Amount: $298,772	Year 4 Estimated Outcome Amount: $463,378	Year 5 Estimated Outcome Amount: $1,108,078
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $2,119,356			

Identifying Outcome Measure and Provider Information:

Outcome Measure: IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone measure)
Unique Category 3 Identifier: 135235306.3.3
Performing Provider: Medical Center Health System TPI: 135235306

Outcome Measure Description:
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 Early Elective Delivery Rate

Outcome Improvement Targets for each year:

- DY4:
    - IT-3.2: Decrease the Early Elective Delivery Rate by TBD%
- DY5:
    - IT-3.2: Decrease the Early Elective Delivery Rate by TBD%

Rationale:

Process milestones – P-1, P-2, and P-4 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new project for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program. For DY3, we will be implementing the program; therefore several PDSA cycles will be needed in order to determine the best practices for this program moving forward. The baseline rate will be established during DY3 as the initial phases of the project are implemented.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 10% in DY4 and 15% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This outcome is supported by numerous national organizations and is one of the most discussed topics in OB/GYN medical services. Initiatives through the March of Dimes have brought national attention to this outcome and MCHS feels that it accurately reflects the goals of our Women's group expansion. MCHS wants to ensure that every expectant mother in Ector County receives the highest level of prenatal care available and a large part of that message revolves around the benefits of carrying babies to full-term.

135235306.3.3	***3.IT-8.3***	***Early Elective Delivery***	
Medical Center Health System			
Related Category 1 or 2 Projects	***Expansion of Women's Health Services Access in Ector County 135235306.1.3***		
Starting Point/Baseline	***Baseline will be established DY3***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1]: Project Planning- Development of clinical protocols and clinic space. Data Source: Project Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $239,126	**Process Milestone 2 [P-2**]: Establish baseline rate for early elective delivery % Data Source: EHR Process Milestone 3 Estimated Incentive Payment: $277,179	**Outcome Improvement Target 1** [IT-8.3]: Improvement Target: TBD% decrease over established baseline in early elective delivery Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $444,775	**Outcome Improvement Target 2** [IT-8.3]: Improvement Target: TBD% decrease over established baseline in early elective delivery Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,063,593
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $239,126	Year 3 Estimated Outcome Amount: $277,179	Year 4 Estimated Outcome Amount: $444,775	Year 5 Estimated Outcome Amount: $1,063,593
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $2,024,673			

Identifying Outcome Measure and Provider Information:
Outcome measure: IT 6.1 Patient satisfaction
Unique RHP outcome identification number 135235306.3.4
Performing Provider: Medical Center Health System 135235306

Outcome Measure Description:
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 Patient Satisfaction Scores- Communication with Doctors scores specifically

Outcome Improvement Targets for each year:

- DY4:
    - IT 6.1: Increase Patient satisfaction scores by 5% in the realm of physician communication
- DY5:
    - IT 6.1: Increase Patient satisfaction scores by 10% in the realm of physician communication

Rationale:

Process milestones – P-1 and P-2 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new method for interpretation for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program. For DY3, we will be implementing the program; therefore the baseline rate will be established during DY3 as the program goes house wide.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 5% in DY4 and 10% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This outcome is supported by numerous national organizations and is one of the most discussed topics in hospitals today. With the implementation of Value-based purchasing, Patient Satisfaction will become an even more important goal for hospitals to strive for. Language barriers will only continue to grow in this area and by being proactive MCHS can ensure that all patients' needs and doctors' orders are understood by all parties.

135235306.3.4	***3.IT 6.1***	***Patient Satisfaction***	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.1.4***		
Starting Point/Baseline	***New Program***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [*P-1*]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning Materials Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $52,387	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: Patient Satisfaction Surveys Process Milestone 2 Estimated Incentive Payment: $60,723	**Outcome Improvement Target 1** [IT-6.1-2]: How well their Doctor Communicates Improvement Target: 5% increase in scores over DY 3 Baseline Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $97,439	**Outcome Improvement Target 2** [IT-6.1-2]: How well their Doctor Communicates Improvement Target: 10% increase in scores over DY3 Baseline Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $233,008
Year 2 Estimated Outcome Amount: $52,387	Year 3 Estimated Outcome Amount: $60,723	Year 4 Estimated Outcome Amount: $97,439	Year 5 Estimated Outcome Amount: $233,008
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $443,557			

Identifying Outcome Measure and Provider Information:

Outcome Measure: IT 3.2 Congestive Heart Failure 30 Day Readmission Rate
Unique Category 3 Identifier: 135235306.3.5
Performing Provider: Medical Center Health System 135235306

Outcome Measure Description:

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 30-Day CHF Readmission Rate
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
    - IT-3.2: Decrease the 30 Day CHF Readmission Rate by 15%
- DY5:
    - IT-3.2: Decrease the 30 Day CHF Readmission Rate by 20%

Rationale:

Process milestones – P-1, P-2, and P-4 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new project for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program, For DY3, we will be implementing the program, therefore several PDSA cycles will be needed in order to determine the best practices for this program moving forward. The baseline rate will be established during DY3 as the initial phases of the project are implemented.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 15% in DY4 and 20% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Congestive Heart Failure patients are at greater risk than most of developing life altering complications and therefore, we feel that the health system must adapt our practices to meet the needs of our community. Many of these patients are unaware of how to properly control their disease and therefore are at high risk of readmissions. MCHS feels that by revamping the way we handle these patients in the outpatient market we can significantly reduce readmission and even admissions. MCHS understands that by utilizing navigation and innovative treatments we can identify more patients and direct them to the proper site of care. The continually increasing number of uninsured and underinsured patients presenting to our ED for primary care or potentially preventable diseases has created a financial burden on the hospital district, in addition to resulting in suboptimal patient outcomes.

135235306.3.5	***3.IT 3.2***	***Congestive Heart Failure 30 Day Readmission Rate***	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.2.1***		
Starting Point/Baseline	***26% Readmission Rate in DY1, Measurement will be based upon DY3 rates***		
Year 2 **(10/1/2012-9/30/2013)**	**Year 3** **(10/1/13-9/30/14)**	**Year 4** **(10/1/14-9/30/15)**	**Year 5** **(10/1/15-9/30/16)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Planning documentation **Process Milestone 1 Estimated Incentive Payment *(maximum amount): $***115,646	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EHR, Performance Improvement Process Milestone 2 Estimated Incentive Payment: $67,024 **Process Milestone 3 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Completed PDSA Plans Process Milestone 3 Estimated Incentive Payment: $67,025	**Outcome Improvement Target 1 [IT-3.2]:** Congestive Heart Failure 30 day readmission rate Improvement Target: 10% Reduction in CHF 30 Day Readmission Rate Data Source: EHR, Performance Improvement Outcome Improvement Target 2 Estimated Incentive Payment*:* $215,102	**Outcome Improvement Target 2 [IT-3.2]:** Congestive Heart Failure 30 day readmission rate Improvement Target: 20% Reduction in CHF 30 Day Readmissions Data Source: EHR, Performance Improvement Outcome Improvement Target 3 Estimated Incentive Payment*:* $514,374
Year 2 Estimated Outcome Amount: $115,646	Year 3 Estimated Outcome Amount: $134,049	Year 4 Estimated Outcome Amount: $215,102	Year 5 Estimated Outcome Amount: $514,374
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $979,171			

Identifying Outcome Measure and Provider Information:
Outcome Measure: IT 3.1 All Cause 30-day Readmission Rate
Unique Category 3 Identifier: 135235306.3.6
Performing Provider: Medical Center Health System 135235306

Outcome Measure Description:
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 30-Day All Cause Readmission Rate
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
    - IT-3.1: Decrease the 30 Day All Cause Readmission Rate by 10%
- DY5:
    - IT-3.1: Decrease the 30 Day All Cause Readmission Rate by 15%

Rationale:

Process milestones – P-1, P-2, and P-4 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new project for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program, For DY3, we will be implementing the program, therefore several PDSA cycles will be needed in order to determine the best practices for this program moving forward. The baseline rate will be established during DY3 as the initial phases of the project are implemented.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 10% in DY4 and 15% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. "At Risk" patients are at greater risk than most of developing life altering complications and therefore, we feel that the health system must adapt our practices to meet the needs of our community. Many of these patients are unaware of the options available to them in the outpatient market and therefore rely on emergency services for care instead of proactively managing their disease. MCHS understands that by directing patients to the proper site of care that we can divert some of the costs associated with lengthy inpatient stays. By having navigators in the community we are providing these patients with an advocate that can help them work through a very complicated healthcare environment. By going to the patient we should be able to decrease all cause readmissions down the line, which will represent significant costs savings to all parties involved, but more importantly we will increasing the quality of life for our patients.

135235306.3.6	*3.IT 3.1*	*All Cause 30 Day Readmission Rate*	
Medical Center Health System			
Related Category 1 or 2 Projects	*135235306.2.2*		
Starting Point/Baseline	*New Program, Current Rate is 17.5% according to Hospital Compare*		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $125,713	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EHR, Performance Improvement Process Milestone 2 Estimated Incentive Payment: $72,859 **Process Milestone 3 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Completed PDSA Plans Process Milestone 3 Estimated Incentive Payment: $72,859	**Outcome Improvement Target 1 [IT-3.1]:** All cause 30 day readmission rate- NQF 1789 Improvement Target: 10% reduction in the rate Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $233,827	**Outcome Improvement Target 2 [IT-3.1]:** All cause 30 day readmission rate- NQF 1789 Improvement Target: 15% reduction in the rate Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $569,152
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $125,713	Year 3 Estimated Outcome Amount: $145,718	Year 4 Estimated Outcome Amount: $233,827	Year 5 Estimated Outcome Amount: $569,152
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,074,410			

Identifying Outcome Measure and Provider Information:

Outcome Measure: IT 4.8 Sepsis Mortality
Unique Category 3 Identifier: 135235306.3.7
Performing Provider: Medical Center Health System 135235306

Outcome Measure Description:

According to the Institute for Healthcare Improvement (IHI), sepsis is the leading cause of death in the ICU and the national mortality rate is 30-50%. Even after a patient has survived this illness, the patient remains at risk of dying within the first month of survival (30%) and within 6 months (50%) (IHI). It is estimated that severe sepsis and septic shock treatments tally up to $17 billion annually in healthcare costs (Warren & Ruppert, 2012).

Upon completion of DY 5, the mortality rates from severe sepsis will be 15% less than the baseline, which will be established during DY 2.

Rationale:

The first phase of our program will be to establish in detail the time lapse from the 1st evidence of infection-related organ dysfunction/failure to activation of RRT (or time to initiation of RRT-independent resuscitative efforts), and meeting time-based resuscitative and infection control measures. Patients will be identified through the ongoing severe sepsis management program database and RRT records. We will further analyze the association the timeliness of diagnosis and resuscitative intervention and patients' outcomes (hospital mortality).

In addition, the Severe Sepsis Management Group and hospital's Information Technology staff will convene to review present capabilities of the local health information systems to track and identify electronically posted indicators suggestive of severe sepsis.

Among patients hospitalized with severe sepsis at Medical Center Hospital during the period between 2006 through 2010, 41% were minority. Among non-Medicare patients, 56% had either Medicaid or no health insurance. The latter figure was 43% among Caucasians, 72% for Hispanics, and 76% for Blacks. These figures underscore the disproportionate representation of groups more likely to develop severe sepsis and incur adverse outcomes as a result.

Outcome Measure Valuation:

For this project, our two focuses are community outreach and awareness, and improving early diagnosis and resuscitation of ward patients. The populations served in Ector County Hospital District (ECHD) include those from outlying facilities within the region. Often times, they are underprivileged and of non-English speaking language. Therefore, to provide community outreach and awareness, we will need to consider the best location to teach awareness, as well as provide a form of interpretation, for both written materials and in-person.

For the ward identification of patients, hiring nurses and training them to do comprehensive concurrent monitoring of the highest risk patients will help to identify the patients before the risk of severe sepsis sets in. The time and financial resources to train these nurses would occur during DY 3.

In 2012, there were 245 severe sepsis/septic shock patients. 54 of the patients died, which is a 22% overall mortality rate for 2012. The goal is to have a 15% reduction in mortality by Year 5 of the Waiver. This would mean that we would hold a consistent overall mortality rate of 19%.

135235306.3.7	*3.IT-4.8*	*Sepsis Mortality*	
Medical Center Health System			
Related Category 1 or 2 Projects:	*135235306.2.3*		
Starting Point/Baseline	*Will be established in DY2*		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning activities Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,417 **Process Milestone 2** [**P-2**]: Establish baseline rates. Data Source: EHR, Performance Improvement, Program Materials Process Milestone 2 Estimated Incentive Payment: $25,418	**Process Milestone 3 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Training Documentation Process Milestone 3 Estimated Incentive Payment: $58,924	**Outcome Improvement Target 1** [IT-4.8]: Decrease sepsis mortality rates from baseline, determined during DY 2 Improvement Target: 10% decrease in sepsis mortality Data Source: Sepsis Data Set Outcome Improvement Target 1 Estimated Incentive Payment*:* $94,552	**Outcome Improvement Target 3** [IT-4.8]: Decrease sepsis mortality rates from baseline, determined during DY 2 Improvement Target: 15% reduction in Sepsis Mortality Rate Data Source: Sepsis Data set Outcome Improvement Target 1 Estimated Incentive Payment*:* $226,104
Year 2 Estimated Outcome Amount: $50,835	Year 3 Estimated Outcome Amount: $58,924	Year 4 Estimated Outcome Amount: $94,552	Year 5 Estimated Outcome Amount: $226,104
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $430,415			

Identifying Outcome Measure and Provider Information:

Outcome Measure: IT-4.7 Hospital-acquired Deep pressure ulcers (Standalone measure)
Unique Category 3 Identifier: 135235306.3.8
Medical Center Health System TPI: 135235306

Outcome Measure Description:

Reduce the occurrence of hospital acquired pressure ulcers incrementally by 25% throughout the entire facility by year 5. This will be accomplished through the establishment of "Mobility Teams" throughout the facility and with the full time employment of a Certified Wound & Ostomy Nurse.

Rationale:

Pressure ulcers are costly, physically debilitating, and potentially preventable events occurring in acute care settings. The risk of missed reimbursement far outweighs the implementation costs of an innovative resource-driven Mobility Team to reduce risk in hospitalized patients. With an increase in national attention to achieve optimal patient outcomes while reducing operating costs, it is essential for leaders and clinicians to embrace innovative approaches to deliver patient care. Traditional prevention strategies may not truly suffice existing patient needs. Therefore, a proactive approach to meeting resource gaps is necessary. The implementation of a Mobility Team can help address practical issues facing the nursing profession. The average cost to treat a pressure ulcer is $43,000 (Centers for Medicare & Medicaid Services, 2008). 17,000 lawsuits and 60,000 deaths annually are associated with ulcers, with over 2.5 million patients affected each year (AHRQ, 2011; Reddy, Gill & Rochon, 2006). Prevention is fundamental requiring new strategies to educate & empower patients. As a cost effective strategy, the Mobility Team was designed to supplement the multidisciplinary team with a specific goal of reducing patients' risk for pressure ulcer development through: education, patient/family engagement, and improved mobility. The utilization of all available resources is vital to ensure economic salience and to promote quality of care. The implementation of a cost-effective team as a prevention strategy can potentially yield favorable outcomes for patients. The Mobility Team model was piloted on two medical units with preliminary favorable patient outcomes and feedback. The 1115 Medicaid Waiver plan now is to expand the mobility team model throughout the entire facility to reduce pressure ulcer incidence at the system level. In addition, there is a pressing need to employ a full time certified Wound and Ostomy Nurse within the system, which currently does not exist, to further support staff in the reduction of ulcers through education, rounding, and direct patient care as needed.

Outcome Measure Valuation:

This project was approached from a cost avoidance perspective. According to CMS, the average cost to treat a pressure ulcer is over $43,000. Therefore, in terms of cost avoidance and due to historical pressure ulcer data, it was deemed cost effective to implement mobility teams throughout the facility in an effort to reduce the burden that hospital acquired ulcers place on

patients, families, caregivers, other healthcare providers and facilities, and ultimately on the community.

135235306.3.8	*3.IT-4.7*	*Hospital-acquired Deep pressure ulcers*	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.2.4-Mobility Teams/Pressure Ulcers***		
Starting Point/Baseline	***Baseline will be established DY2***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Documentation of planning activities Process Milestone 1 Estimated Incentive Payment *(maximum amount):* **$51,875** Process Milestone 2 [P-2]: Establish baseline rates Data Source: EHR/Program Data Process Milestone 2 Estimated Incentive Payment (maximum amount): **$51,874**	**Outcome Improvement Target 1 [IT-4.7]:** 10% reduction in hospital acquired pressure ulcer rates from original baseline Data Source: EHR Baseline- 9.7% baseline average (10% reduction moves to 8.73%) Outcome Improvement Target 1 Estimated Incentive Payment: **$120,258**	**Outcome Improvement Target 2 [IT-4.7]:** Improvement Target: 15-20% reduction in hospital acquired pressure ulcer rates from original baseline Baseline- 9.7% baseline average (20% reduction moves to 7.76%) Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* **$207,972**	**Outcome Improvement Target 3 [IT-4.**7]: Improvement Target: 25% reduction in hospital acquired pressure ulcer rates from original baseline Baseline- 9.7% baseline average (25% reduction moves to 7.3%) Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* **$461,456**
Year 2 Estimated Outcome Amount: **$103,749**	Year 3 Estimated Outcome Amount: **$120,258**	Year 4 Estimated Outcome Amount: **$207,972**	Year 5 Estimated Outcome Amount**:$461,456**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $893,435			

Identifying Outcome Measure and Provider Information:
Outcome Measure: IT 2.9 Uncontrolled Diabetes Admissions Rate- PQI 14245
Unique Category 3 Identifier: 135235306.3.9
Performing Provider: Medical Center Health System TPI: 135235306

Outcome Measure Description:
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 Uncontrolled Diabetes Admission Rate
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome Improvement Targets for each year:

- DY4:
    - IT-3.2: Decrease the Uncontrolled Diabetes Admissions Rate by 10%
- DY5:
    - IT-3.2: Decrease the Uncontrolled Diabetes Admissions Rate by 15%

Rationale:

Process milestones – P-1, P-2, and P-4 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new project for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program, For DY3, we will be implementing the program, therefore several PDSA cycles will be needed in order to determine the best practices for this program moving forward. The baseline rate will be established during DY3 as the initial phases of the project are implemented.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 10% in DY4 and 15% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Diabetic patients are at greater risk than most of developing life altering complications and therefore, we feel that the health system must adapt our practices to meet the needs of our community. Many of these patients are unaware of their disease and therefore do not understand the regimen needed to properly control their diabetes. The Health Department and MCHS understand that by utilizing each other's strengths we can identify more patients and direct them to the proper site of care. By going to the patient we should be able to decrease uncontrolled diabetic admissions down the line. The continually increasing number of uninsured and underinsured patients presenting to our ED for primary care or potentially preventable diseases has created a financial burden on the hospital district, in addition to resulting in suboptimal patient outcomes.

135235306.3.9	*3.IT 2.9*	*Uncontrolled Diabetes Admissions Rate-PQI 14245*	
Medical Center Health System			
Related Category 1 or 2 Projects	*135235306.2.5*		
Starting Point/Baseline	*New Program*		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation Plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 143,951	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EHR, Program Registry Process Milestone 3 Estimated Incentive Payment: $74,260 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: PDSA Documentation Process Milestone 3 Estimated Incentive Payment*:* $74,259	**Outcome Improvement Target 1 [IT-2.9]:** Improvement Target: Uncontrolled Diabetes Admissions Rate cut by 10% Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $238,322	**Outcome Improvement Target 2 [IT-2.9]:** Improvement Target: Uncontrolled Diabetes Admissions Rate cut by 15% Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $569,900
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ $143,951	Year 3 Estimated Outcome Amount: $155,266	Year 4 Estimated Outcome Amount: $249,148	Year 5 Estimated Outcome Amount: $595,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,144,154			

Identifying Outcome Measure and Provider Information:
Outcome Measure: IT 13.6 Other Outcome Improvement Target NQF 0703 Intensive Care: In-hospital mortality rate
Unique Category 3 Identifier: 135235306.3.10
Performing Provider: Medical Center Health System TPI: 135235306

Outcome Measure Description:
MEASURE DESCRIPTION:
For all adult patients admitted to the intensive care unit (ICU), the percentage of patients whose hospital outcome is death; both observed and risk-adjusted mortality rates are reported with predicted rates based on the Intensive Care Outcomes Model - Mortality (ICOMmort).

NUMERATOR STATEMENT:
Total number of eligible patients whose hospital outcome is death

DENOMINATOR STATEMENT:
Total number of eligible patients who are discharged (including deaths and transfers)

EXCLUSIONS:
<18 years of age at time of ICU admission, ICU readmission, <4 hours in ICU, primary admission due to trauma, burns, or immediately post-CABG, admitted to exclude myocardial infarction (MI) and subsequently found without MI or any other acute process requiring ICU care, transfers from another acute care hospital

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 the Intensive Care-in-hospital mortality rate (NQF 0703)

Outcome Improvement Targets for each year:

- DY4:
    - IT-13.6: Decrease the Intensive Care-in-hospital mortality rate (NQF 0703) by TBD%

- DY5:
    - IT-13.6: Decrease the Intensive Care-in-hospital mortality rate (NQF 0703) by TBD%

Rationale:

Process milestones – P-1, P-2, and P-4 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new project for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program, For DY3, we will be implementing the program, therefore several PDSA cycles will be needed in order to determine the best practices for this program moving forward. The baseline rate will be established during DY3 as the initial phases of the project are implemented.

Improvement targets were selected to accurately reflect the intent of this project. We want to ensure that patients are navigated to the proper venue, which keeps costs low and keep the patient in a more comfortable setting. MCHS feels that IT target percentages cannot be computed at this time due to the inadequacy of the palliative care process.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project.

135235306.3.10	***3.IT-13.6***	***Other Outcome Improvement Target: NQF 0703 Intensive Care: In-hospital mortality rate***	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.2.6- MCHS Palliative Care Program***		
Starting Point/Baseline	***No real program, baseline will be established at the conclusion of DY3***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [**P-1**]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Business Case Submission Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $125,646	**Process Milestone 2 [P-2]:** Establish Baseline Rates Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $134,049	**Outcome Improvement Target 1** [IT-13.6]: Intensive Care: In-hospital mortality rate NUMERATOR STATEMENT: Total number of eligible patients whose hospital outcome is death DENOMINATOR STATEMENT: Total number of eligible patients who are discharged (including deaths and transfers) Improvement Target: TBD% reduction over DY 3 baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $215,102	**Outcome Improvement Target 3** [IT-13.6]: Intensive Care: In-hospital mortality rate NUMERATOR STATEMENT: Total number of eligible patients whose hospital outcome is death DENOMINATOR STATEMENT: Total number of eligible patients who are discharged (including deaths and transfers) Improvement Target: TBD% reduction over DY 3 Baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $514,375
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $125,626	Year 3 Estimated Outcome Amount: $134,049	Year 4 Estimated Outcome Amount: $215,102	Year 5 Estimated Outcome Amount: $514,375
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $989,152			

Identifying Outcome Measure and Provider Information:
Outcome measure: IT 12.1 Breast Cancer Screening
Unique RHP outcome identification number: 135235306.3.11
Performing Provider: Medical Center Health System 135235306

Outcome Measure Description:
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 Breast Cancer Screening Rates in women 40 to 69

Outcome Improvement Targets for each year:

- DY4:
    - IT 12.1: Increase number of women 40 to 69 who have received an annual mammogram by 5% over established DY3 Baseline
- DY5:
    - IT 12.1: Increase number of women 40 to 69 who have received an annual mammogram by 10% over established DY3 Baseline

Rationale:

Process milestones – P-1 and P-2 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new method for interpretation for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program. For DY3, we will be implementing the program; therefore the baseline rate will be established during DY3 as the program goes house wide.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 5% in DY4 and 10% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This outcome is supported by numerous national organizations, like Susan G. Komen and is one of the most basic screenings that most women get. Unfortunately in our area only about 50% of women get their annual mammogram. MCHS and other regional partners have held numerous events to try and get the word out, but we have had limited success. Through this project we hope to reach more community members than ever to ensure that every woman in Ector County and RHP 14 are aware of the need to have an annual mammogram.

135235306.3.11	***3.IT 12.1***	***Breast Cancer Screening***	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.2.7***		
Starting Point/Baseline	***New Program***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [*P-1*]: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Business Case Submission Process Milestone 1 Estimated Incentive Payment (maximum amount): $35,498	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $41,147	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening Rate in Women 40 to 69 Improvement Target: 5% increase over DY3 baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $69,513	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening Rate in Women 40 to 69 Improvement Target: 10% increase over DY 3 Baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $167,889
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $35,498	Year 3 Estimated Outcome Amount: $41,147	Year 4 Estimated Outcome Amount: $69,513	Year 5 Estimated Outcome Amount: $167,889
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $314,047			

Identifying Outcome Measure and Provider Information:
Outcome measure: IT 12.3 Colorectal Cancer Screening
Unique RHP outcome identification number: 135235306.3.12
Performing Provider: Medical Center Health System

Outcome Measure Description:
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 Colorectal Cancer Screening Rates for aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years.

Outcome Improvement Targets for each year:

- DY4:
    - IT 12.3: Increase number of adults screened for Colorectal Cancer by 5%
- DY5:
    - IT 12.3: Increase number of adults screened for Colorectal Cancer by 10%

Rationale:

Process milestones – P-1 and P-2 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new method for interpretation for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program. For DY3, we will be implementing the program; therefore the baseline rate will be established during DY3 as the program goes into full effect.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 5% in DY4 and 10% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Diagnosis of cases of colorectal cancer through screening tends to occur 2–3 years before diagnosis of cases with symptoms. Screening has the potential to reduce colorectal cancer deaths by 60% according to different national opinion leaders. Colorectal cancer screening reveals a problem, diagnosis and treatment can occur promptly. In addition, finding and removing polyps or other areas of abnormal cell growth may be one of the most effective ways to prevent colorectal cancer development. Also, colorectal cancer is generally more treatable when it is found early, before it has had a chance to spread. All of these factors lead us to believe that this outcome fits with the needs of the community and allows us to value this project at this level.

135235306.3.12	***3.IT 12.3***	***Colorectal Cancer Screening***	
Medical Center Health System			
Related Category 1 or 2 Projects	***135235306.2.7***		
Starting Point/Baseline	***New Program***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [*P-1*]: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Business Case Submission Process Milestone 1 Estimated Incentive Payment (maximum amount): $35,498	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $41,147	**Outcome Improvement Target 1** [IT-12.3]: Colorectal Cancer Screening Rates for aged 50 to 75 Improvement Target: 5% increase over DY3 baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $69,513	**Outcome Improvement Target 2** [IT-12.3]: Colorectal Cancer Screening Rates for aged 50 to 75 Improvement Target: 10% increase over DY 3 Baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $167,889
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $35,498	Year 3 Estimated Outcome Amount: $41,147	Year 4 Estimated Outcome Amount: $69,513	Year 5 Estimated Outcome Amount: $167,889
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $314,047			

Identifying Outcome Measure and Provider Information:
Outcome measure: IT 12.4 Pneumonia Vaccination Rate
Unique RHP outcome identification number: 135235306.3.13
Performing Provider: Medical Center Health System 135235306

Outcome Measure Description:
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 Number of adults aged 65 and older that have ever received a pneumonia vaccine.

Outcome Improvement Targets for each year:

- DY4:
    - IT 12.4: Increase Number of adults aged 65 and older that have ever received a pneumonia vaccine by 5%
- DY5:
    - IT 12.4: Increase Number of adults aged 65 and older that have ever received a pneumonia vaccine by 10%

Rationale:

Process milestones – P-1 and P-2 were chosen due to the startup procedures needed to accurately report on this measure. Considering that this is a completely new method for interpretation for MCHS, it will be necessary to perform proper planning sessions in DY 2 to ensure that all stakeholders are in concert with the overall goal of the program. For DY3, we will be implementing the program; therefore the baseline rate will be established during DY3 as the program goes house wide.

Improvement targets were set based on the short timeframe of the waiver. MCHS feels that IT targets of 5% in DY4 and 10% in DY5 accurately reflect the amount of progress that can be achieved given the limited timeframe and scope of what we are trying to accomplish.

Outcome Measure Valuation:

The valuation of each MCHS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the

project (both number of people and complexity of patient needs), and investment required to implement the project. This measure was chosen based on our current commitment to providing the pneumonia vaccine for all inpatients of a certain age. While, this program has been successful, our mortality and readmission rates for pneumonia continue to be above national and state averages. By focusing on this measure we can refocus our efforts to get this vaccine into the outpatient market (i.e. Nursing Homes, Assisted Living, Senior Centers), instead of waiting until they are admitted.

135235306.3.13	IT 12.4	Pneumonia vaccination status for older adults	
Medical Center Health System			
Related Category 1 or 2 Projects	**135235306.2.7**		
Starting Point/Baseline	**New Program- We have internal data**		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [*P-1*]: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Business Case Submission Process Milestone 1 Estimated Incentive Payment (maximum amount): $35,498	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $41,147	**Outcome Improvement Target 1** [IT-12.4]: Number of adults aged 65 and older that have ever received a pneumonia vaccine Improvement Target: 5% increase over DY3 baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $69,513	**Outcome Improvement Target 2** [IT-12.4]: Number of adults aged 65 and older that have ever received a pneumonia vaccine Improvement Target: 10% increase over DY 3 Baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $167,889
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $35,498	Year 3 Estimated Outcome Amount: $41,147	Year 4 Estimated Outcome Amount: $69,513	Year 5 Estimated Outcome Amount: $167,889
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $314,047			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.1
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
in collaboration with Premier Physicians
Title of Outcome Measure (Improvement Target):
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) *(Standalone measure)*

- **Outcome Measure Description:**

Controlling High Blood Pressure IT-1.7. Our recruitment focuses on family practitioners ("FPs") which will allow Midland residents greater access to basic health care. FPs can screen patients for symptoms suggesting they are at risk for high-blood pressure, provide education to patients to prevent the onset of high blood pressure, diagnose existing high-blood pressure conditions, prescribe medication and lifestyle changes to control high-blood pressure, and monitor the patient's condition in the long term. In short, the recruitment of FPs will afford many of the earlier and additional interventions necessary for controlling high blood pressure.

- **Rationale:**

33.5 percent of the people in the United States have high blood pressure and RHP14 reports a higher rate of heart disease than that of the Rest of Texas. Clinical trials have shown aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure, results that are particularly striking in elderly hypertensives. RHP 14's percentage of older adults is expected to grow in the next 20 years, which will present greater requirement for basic health care. Guidelines from the USPSTF and the Joint National Committee indicate 53% percent of people under treatment achieved control of their blood pressure.

Since RHP 14 has higher death rates than Texas for heart disease, high blood pressure is a contributing factor to heart disease, and our Medicaid, Medicare , uninsured population of our community have experienced limited access to care in obtaining treatment for chronic health issues; we have chosen IT1.7 as an outcome measure to assist the 33.5 % of the population who have high blood pressure issues and who have experienced limited access to care. We hope by bringing additional primary care providers to our area, the underserved population will achieve control of the their high blood pressure and this will improve the quality of life and improve mortality rates in our community and RHP 14.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Primary Care Recruitment project uses a method which ranks the importance of each project based several key factors. First, Midland considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community. Next, Midland considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of

the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Midland reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. Therefore, the value of this project varies in relation to the overall community benefit of the primary care recruitment project. The value of accomplishing the improvement target for this outcome domain is multifold: it will improve patient health outcomes, patient quality of life, patient functionality, and will reduce the short term and long terms costs of treating the consequences of uncontrolled high blood pressure.

136143806.3.1	***3.IT.1.7***	***Controlling high blood pressure***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.1.1***		
Starting Point/Baseline:	*53 percent of patients ages 18 to 85 under treatment achieve control of their blood pressure to levels less than 140/90/mm Hg.*		
Year 2 (10/1/2012 – 9/30/2013)	**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] Controlling High Blood Pressure. Develop a project plan to engage present providers and new providers to identify capacities of care and resources needed to record patient vital signs which include blood pressure levels, improvement in levels, and research for comparative data that indicates that patient hypertensive levels are adequately controlled. Process Milestone 2 [P-2 &3] Controlling High Blood Pressure. Develop and test data systems to establish baseline measurements of patients 18 to 85 years of age with a diagnosis of hypertension, test system for measurement of reductions in readings for follow-up appointments, and establish frequency of reporting required to determine baseline. Process Milestone 1 Estimated Incentive Payment: $95,685 Process Milestone 2 Estimated Incentive Payment: $95,686	Process Milestone 3 [P-5] Controlling High Blood Pressure Disseminate findings, including lessons learned and best practices to stakeholders. Process Milestone 3 Estimated Incentive Payment: $332,737	Outcome Improvement Target 1 [IT-1.7] Controlling High Blood Pressure Target – 58% of patients treated for hypertension will have controlled levels of blood pressure less than 140/90 mm Hg during measurement year. Metric [IT-1.7.a&b] Numerator: The number of patients in the denominator most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Current guidelines indicate at least 53 percent of people under treatment achieved control of their blood pressure to levels less than 140/90mm Hg. Data Source: EHR Outcome Improvement Target 1	Outcome Improvement Target 2 [IT-1.7] Controlling High Blood Pressure Target – 63% of patients treated for hypertension will have controlled levels of blood pressure less than 140/90 mm Hg during measurement year. Metric:[IT-1.7.a&b] Numerator: The number of patients in the denominator most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Current guidelines indicate at least 53% of people under treatment achieved control of their blood pressure to levels less than 140/90mm Hg. Data Source: EHR Outcome Improvement Target 2

136143806.3.1	***3.IT.1.7***	***Controlling high blood pressure***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.1.1***		
Starting Point/Baseline:	*53 percent of patients ages 18 to 85 under treatment achieve control of their blood pressure to levels less than 140/90/mm Hg.*		
Year 2 (10/1/2012 – 9/30/2013)	**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*:* $830,552	Estimated Incentive Payment*:* $1,289,677
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $191,371	Year 3 Estimated Outcome Amount: $332,737	Year 4 Estimated Outcome Amount: $830,552	Year 5 Estimated Outcome Amount: $1,289,677
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,644,337			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.2
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate utilization

- **Outcome Measure Description:**

Our goal is to assist the community in understanding appropriate utilization of the ED through education via 68Nurse and providing an alternative access to non-emergent care.

- **Rationale:**

Expanding access to the nurse advice line will decrease the number of non-emergent patients utilizing the ED. The decrease in non-emergent patients improves access for emergent/critical patients needing immediate care.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's 68Nurse (reduction in inappropriate ED usage) project uses a method which ranks the importance of each project based several key factors. First, Midland considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Midland considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Midland reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. Therefore, the value of this project varies in relation to the overall community benefit of reducing inappropriate ED utilization. This project seeks reduce the cost of delivering care in the community by addressing quality patient care in a cost efficient model and attempting to reduce potentially preventable hospitalizations. Too many area residents currently use the ED as their primary health care point of contact. By directing appropriate care, MMH will help

provide more appropriate care, more cost effective care, and better health outcome for area residents. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run.

136143806.3.2	***3.IT-9.2***	***ED Appropriate Utilization***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.1.2***		
Starting Point/Baseline:	***To be determined 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.2: Establish baseline rates for inappropriate ED utilization using Tier levels Data Source: Claims Process Milestone 1 Estimated Incentive Payment: $105,254	Outcome Improvement Target 1 IT-9.2. Reduce all ED visits from DY2 established baseline rates based on Tier level. Target: Reduce all ED visits by TBD% Metric: Change in the # of inappropriate ED visits between DY3 and DY2 # of inappropriate ED visits in DY2 Data Source: Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $183,005	Outcome Improvement Target 2 IT-9.2. Reduce all ED visits from DY2 established baseline rates based on Tier level. Target: Reduce all ED visits by TBD% Metric: Change in the # of inappropriate ED visits between DY4 and DY2 # of inappropriate ED visits in DY2 Data Source: Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $456,804	Outcome Improvement Target 3 T-9.2 Reduce all ED visits from DY2 established baseline rates based on Tier level. Target: Reduce all ED visits by TBD% Metric: Change in the # of inappropriate ED visits between DY5 and DY2 # of inappropriate ED visits in DY2 Data Source: Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $709,322
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $105,254	Year 3 Estimated Outcome Amount: $183,005	Year 4 Estimated Outcome Amount: $456,804	Year 5 Estimated Outcome Amount: $709,322
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,454,385			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.3
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
In collaboration with Midland Community Health Care Services (local FQHC)
Title of Outcome Measure (Improvement Target): IT.8.2 - Percentage of Low Birth Weight Births

- **Outcome Measure Description:**

Premature delivery and low birth weight are common results of inadequate prenatal care, and can lead to high cost NICU stays, a variety of birth defects, and resultant long-term disability. Early diagnosis of pregnancy and referral for prenatal care in the first trimester can improve outcomes for uninsured patients who might otherwise experience delayed prenatal care. We believe that the availability of culturally-sensitive obstetrical/gynecological services, in a familiar and safe environment within the underserved area, provides a pathway to prenatal care for low income mothers.

- **Rationale:**

In RHP 14, 9% of newborns have a low birth weight and 40% of pregnant women in the region do not receive prenatal care during their first trimester of pregnancy. The predominantly low-income, uninsured/underinsured population served by Midland Community Healthcare Services has been slightly more likely to receive first trimester prenatal care (72% vs. 60% for RHP 14), but there remains significant room to improve this percentage. Early access to prenatal care is widely recognized as an essential factor in prevention of premature delivery and low birth weight.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Low-Birth Weight project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. By addressing a chronically underserved area of the community, this project will improve access to care, quality of care and health outcomes for newborns. This effort is designed to bring care to area residents who might not have access, particularly those who are uninsured, underinsured, or receive care through government programs. Additionally, the community needs assessment reflects a need for greater pre-natal care and the consequences of a lack of pre-natal care, both of which this project aims to address.

136143806.3.3	***3.IT.8.2***	***Percentage of Low Birth Weight Births***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.1.3***		
Starting Point/Baseline:	**To be determined 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 [P-2.] Establish baseline rates of low birth weight births for targeted population. Data Source: Claims Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $114,823	**Outcome Improvement Target 1** [IT-8.2]: The number of babies born weighing <2,500 grams at birth Improvement Target: TDB% reduction in the number of babies born weighing <2,500 grams at birth Data Source: Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $199,642	**Outcome Improvement Target 2** [IT-8.2]: The number of babies born weighing <2,500 grams at birth Improvement Target: TDB% reduction in the number of babies born weighing <2,500 grams at birth Data Source: Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $498,331	**Outcome Improvement Target 3** [IT-8.2]: The number of babies born weighing <2,500 grams at birth Improvement Target: TDB% reduction in the number of babies born weighing <2,500 grams at birth Data Source: Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $773,806
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $114,823	Year 3 Estimated Outcome Amount: $199,642	Year 4 Estimated Outcome Amount: $498,331	Year 5 Estimated Outcome Amount: $773,806
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,586,602			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.4
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30 day readmission rate – NFQ 1789 (s*tandalone measure)*

- **Outcome Measure Description:**

Enhancing communication and interactions between staff / provider and LEP patient and their families ("interpretation encounters") during their visit to the hospital aids LEPs in understanding their plan of care and discharge instructions. By increasing the number of interpretation encounters, it should proportionally lower readmission rates.

- **Rationale:**

While our Medical Interpreter Program and our video / audio pilot program aid LEP patients to access healthcare, it may be difficult to respond expediently to each LAS request; thus, creating a gap promoting higher readmission rates. In addressing this challenge, we propose expanding remote video / audio interpretation services hospital wide to respond more efficiently to LEP patient's needs and to train staff / providers on how to access LAS to help lower readmission rates.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Potentially Preventable Re-Admissions (PRP) project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Patients most vulnerable to readmission issues include patients with the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. By focusing one element of Midland Memorial's efforts under the Waiver on reducing readmission in these areas, this facility will address quality of care and health outcomes for current patients and make more room available for other patients, improving access to care. These health challenges are also among the leading causes of death in Texas, indicating both a benefit to the region's population and the needs of the community. (CN-1). Additionally, THCIC data indicates RHP14 received approximately $461 million between 2005 and 2011 for preventable hospitalizations. (Community Needs Assessment, page 15) (CN-2). Congestive heart failure represented the largest portion of these expenses at $114 million (Community Needs Assessment, page 15). Focusing on PPRs will maximize funds under the Waiver because of the ongoing benefit to patients of not having to return to a hospital for treatment and reduce preventable hospitalizations.

136143806.3.4	***3.IT.3.1***	***All Cause 30-day readmission rate***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.1.4***		
Starting Point/Baseline:	***96 encounters per month***		
Year 2 **(10/1/2012 – 9/30/2013)**	**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 [*RHP PP Process Milestone* – P-Y]: P-2: Establish baseline rates on population and number of individuals who actually fall within our targeted population, i.e., those individuals using LEP services while patients. Data Source: EHR or other documentation of patient population and agreement to participate in screening and education. Process Milestone 2 Estimated Incentive Payment: $105,254	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate Improvement Target: Reduce # of all cause 30 day readmission rate in targeted population by TBD% Unplanned all-cause 30 day Readmission-target population Total Admissions-targeted population Data Source: Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $183,005	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate Improvement Target: Reduce # of all cause 30 day readmission rate in targeted population by TBD% Unplanned all-cause 30 day Readmission-target population Total Admissions-targeted population Data Source: Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $456,804	**Outcome Improvement Target 3** [IT-3.1]: All cause 30 day readmission rate Improvement Target: Reduce # of all cause 30 day readmission rate in targeted population by TBD% Unplanned all-cause 30 day Readmission-target population Total Admissions-targeted population Data Source: Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $709,322
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $105,254	Year 3 Estimated Outcome Amount: $183,005	Year 4 Estimated Outcome Amount: $456,804	Year 5 Estimated Outcome Amount: $709,322
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,454,385			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.5
Performing Provider Name/TPI: Midland Memorial Hospital / TPI: 136143806
Title of Outcome Measure (Improvement Target): IT-11.1 – Improvement in Clinical Indicator in Hispanic Population – Colorectal Cancer Screening

- **Outcome Measure Description:**

IT.11.1- Improvement in Clinical Indicator in identified disparity group — Assuming that our anecdotal evidence is correct, one of the first targeted specialists will be a gastroenterologist. We are going to look at the prevalence of colorectal cancer screening among our Hispanic population and work for higher utilization rates among this disparate group.

- **Rationale:**

Our Community Needs Assessment has also shown that in our region the following groups are more likely than their counterparts to not access healthcare: women, African-Americans, Hispanics, people younger than 65, those with no high school diploma and people with low income. Since disparate populations are less apt to seek self-referred screenings which will assist us in lowering overall health care costs, this is our target.

- **Outcome Measure Valuation:**

This project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. By targeting clinical improvements in the Hispanic population, Midland Memorial will encourage more people to seek treatment, help improve quality of care, and the eventual outcomes related to follow-up treatment. Nearly half of the region's population identifies as Hispanic, offering a huge potential impact for this project. Additionally, this project is a good return on investment for the expenditure involved because of the current disparity of treatment found in the area's Hispanic population.

136143806.3.5	***3.IT.11.1***	***Improvement in Clinical Indicator in Hispanic Population - Colorectal Cancer Screening***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.1.5***		
Starting Point/Baseline:	***To be determined.***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone [P-2.] Establish baseline rates of colorectal cancer screening among Hispanic population 50+ years of age. Data Source: Claims Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $124,391	**Outcome Improvement Target 1** By end of DY3, increase the number of Hispanic patients 50+ years of age who have a colorectal cancer screening through targeted education and the availability of an additional gastroenterologist. Improvement Target: TDB increase in the number of targeted population getting colorectal cancer screenings over the baseline year Data Source: Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $216,279	**Outcome Improvement Target 2** By end of DY4, increase the number of Hispanic patients 50+ years of age who have a colorectal cancer screening through targeted education and the availability of an additional gastroenterologist. Improvement Target: TDB increase in the number of targeted population getting colorectal cancer screenings over the baseline year Data Source: Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $539,859	**Outcome Improvement Target 3** By end of DY5, increase the number of Hispanic patients 50+ years of age who have a colorectal cancer screening through targeted education and the availability of an additional gastroenterologist. Improvement Target: TDB increase in the number of targeted population getting colorectal cancer screenings over the baseline year Data Source: Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $838,290
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $124,391	Year 3 Estimated Outcome Amount: $216,279	Year 4 Estimated Outcome Amount: $539,859	Year 5 Estimated Outcome Amount: $838,290
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,718,819			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.6
Performing Provider Name/TPI: Midland Memorial Hospital / TPI: 136143806
In collaboration with City of Midland EMS
Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group-Impacting Diabetes

- **Outcome Measure Description:**

EMS represents another avenue to assist in the reduction of the number of undiagnosed and untreated cases of diabetes among the RHP uninsured and underinsured populations in RHP 14. With the integration of 68Nurse and an APRN into selected EMS boxes, we have the opportunity to redirect possible candidates with uncontrolled blood sugar into our collaboration with the City Health Department and MCHS for assessment and screening, care and diabetic self-management training.

- **Rationale:**

10% of Midland County's population over age 19 have diabetes (assuming that Midland is commensurate with the rest of the RHP); the number of residents with pre-diabetes and/or at risk is likely to be significantly higher based on a 29% rate of obesity in the RHP. EMS is often called out for uncontrolled diabetic complications, particularly glucose.

- **Outcome Measure Valuation:**

The valuation of MMH's Diabetes Care project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. ORMC will focus on improving treatment access for patients who might normally wait until manifestation of an emergent condition. This focus on improving access to care will also help improve quality of care, and the eventual outcomes related to follow-up treatment. These objectives are in line with the Waiver's overriding goals. This project is targeting the 10% of local residents with diabetes. Diabetes is currently the sixth leading cause of death in Texas and caused nearly 3,000 potentially preventable hospitalizations in RHP 14 between 2005 and 2010. As a result, this project will target a large segment of the region's population and impact a substantial number of people, particularly the region's uninsured and underinsured patients.

136143806.3.6	***3.IT-11.1***	***Improvement in Clinical Indicator in Identified Disparity Group***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects::	***136143806.2.1***		
Starting Point/Baseline:	***New program, unknown at this time***		
Year 2 (10/1/2012 – 9/30/2013)	**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 Develop specific protocols for interventions with suspected diabetic patients by APRN and 68Nurse. Develop protocols for referring patients to Health Department and/or directly to MCHS. Develop educational materials, etc. Data Source: Documentation of patient population and plan Process Milestone 2 Estimated Incentive Payment: $76,549	**Process Milestone 2** P-2: Establish baseline rates on health disparity population who are potential candidates for assessment and referral. Data Source: EHR or other documentation of patient population and agreement to participate in screening and education. Process Milestone 2 Estimated Incentive Payment: $133,095	Outcome Improvement Target 2 [IT-11.1] Reduce number of non-emergent patients from disparity group who make use of the EMS and/or ED to handle diabetic complications with no follow through by getting them into the screening program involving diabetic self-management training and regular medical management Metric: Decrease the number patients of the targeted patients who call the EMS to handle diabetic complications from baseline data. Percentage decrease - TBD Data Source: EHR; other documentation showing collaboration and process of patient through plan. Outcome Improvement Target 2 Estimated Incentive Payment: $332,221	Outcome Improvement Target 3 [IT-11.1] Reduce number of non-emergent patients from disparity group who make use of the EMS and/or ED to handle diabetic complications with no follow through by getting them into the screening program involving diabetic self-management training and regular medical management Metric: Decrease the number patients of the targeted patients who call the EMS to handle diabetic complications from baseline data. Percentage decrease - TBD Data Source: EHR; other documentation showing collaboration and process of patient through plan. Outcome Improvement Target 3 Estimated Incentive Payment: $515,871
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $76,549	Year 3 Estimated Outcome Amount: $133,095	Year 4 Estimated Outcome Amount: $332,221	Year 5 Estimated Outcome Amount: $515,871
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,057,736			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.7
Performing Provider Name/TPI: Midland Memorial Hospital /TPI: 136143806
In collaboration with City of Midland Health Department and
Midland Community Healthcare Services (local FQHC)
Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) NQF 0059 (Standalone measure)*

- **Outcome Measure Description:**

For DY2, the collaborative will be focusing on establishing baseline rates on what percentage of Health Department users agree to participate in pre-assessment and, depending on results, A1c and foot exam with referrals for further medical care to the local FQHC and for education to the diabetic self-management training classes. For DY3-5, our outcome measures will be IT-1.10 (Diabetic care: HbA1c poor control) and IT-1.13 (Diabetes care Foot exam). Diabetic foot problems are fairly common problems among diabetics which are commonly neglected and can lead to amputation and resultant disability. Early detection, treatment and self-management should lessen the impact, both of frequency and severity of diabetic foot ulcers. We believe that the availability of a screening and self-management training program within the community provides a pathway to treatment for those who need it. We will not know how much improvement we can make in either of these measures until we establish a baseline by the end of DY2.

- **Rationale:** See above in Outcome Measure Description

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Diabetes Care project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Midland Memorial will focus on improving treatment access for patients who might normally wait until manifestation of an emergent condition. This focus on improving access to care will also help improve quality of care, and the eventual outcomes related to follow-up treatment. These objectives are in line with the Waiver's overriding goals. Midland Memorial is targeting the 10% of local residents with diabetes. Diabetes is currently the sixth leading cause of death in Texas and caused nearly 3,000 potentially preventable hospitalizations in RHP 14 between 2005 and 2010. As a result, this project will target a large segment of the region's population and impact a substantial number of people, particularly the region's uninsured and underinsured patients.

136143806.3.7	3.IT-1.10	Diabetes care: HbA1c poor control	
Midland Memorial Hospital			136143806
Related Category 1 or 2 Projects:	136143806.2.2		
Starting Point/Baseline:	New Project; To be determined		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-Y]: P-2: Establish baseline rates on targeted health department population of diabetics between the ages of 18 and 75 years of age and the number of individuals actually agreeing to screening and further tests if warranted. Data Source: EHR or other documentation of patient population and agreement to participate in screening and education. Process Milestone 2 Estimated Incentive Payment: $95,686	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: [IT-1.10.a&b] % TBD of pts. 18-75 years of age with diabetes (I or II) who had hemoglobin A1c (HbA1c)control >9.0% Health Department Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (I or II) Data Source: EHR, Registry, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment*:* $166,368	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: [IT-1.10.a&b] % TBD of pts. 18-75 years of age with diabetes (I or II) who had hemoglobin A1c (HbA1c)control >9.0% Health Department Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (I or II) Data Source: EHR, Registry, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment*:* $415,276	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: [IT-1.10.a&b] % TBD of pts. 18-75 years of age with diabetes (I or II) who had hemoglobin A1c (HbA1c)control >9.0% Health Department Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (I or II) Data Source: EHR, Registry, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment*:* $644,838
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $95,686	Year 3 Estimated Outcome Amount: $166,368	Year 4 Estimated Outcome Amount: $415,276	Year 5 Estimated Outcome Amount: $644,838
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,322,169			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.8
Performing Provider Name/TPI: Midland Memorial Hospital /TPI: 136143806
In collaboration with City of Midland Health Department and
Midland Community Healthcare Services (local FQHC)
Title of Outcome Measure (Improvement Target): IT-1.13 Diabetes care *Foot exam- NQF 0056 (Non- standalone measure)*

- **Outcome Measure Description:**

For DY2, the collaborative will be focusing on establishing baseline rates on what percentage of Health Department users agree to participate in pre-assessment and, depending on results, A1c and foot exam with referrals for further medical care to the local FQHC and for education to the diabetic self-management training classes. For DY3-5, our outcome measures will be IT-1.10 (Diabetic care: HbA1c poor control) and IT-1.13 (Diabetes care Foot exam). Diabetic foot problems are fairly common problem among diabetics and commonly neglected and can lead to amputation and resultant disability. Early detection, treatment and self-management should lessen impact, both of frequency and severity of diabetic foot ulcers. We believe that the availability a screening and self-management training within the community provides a pathway to treatment for those who need it. We won't know how much improvement we can make in either of these measures until we establish a baseline has been established by the end of DY2.

- **Rationale:** See above in Outcome Measure Description

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Diabetes Care project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Midland Memorial will focus on improving treatment access for patients who might normally wait until manifestation of an emergent condition. This focus on improving access to care will also help improve quality of care, and the eventual outcomes related to follow-up treatment. These objectives are in line with the Waiver's overriding goals. Midland Memorial is targeting the 10% of local residents with diabetes. Diabetes is currently the sixth leading cause of death in Texas and caused nearly 3,000 potentially preventable hospitalizations in RHP 14 between 2005 and 2010. As a result, this project will target a large segment of the region's population and impact a substantial number of people, particularly the region's uninsured and underinsured patients.

136143806.3.8	3.IT-1.13	Diabetes care: Foot Exam	
Midland Memorial Hospital			136143806
Related Category 1 or 2 Projects:	136143806.2.2		
Starting Point/Baseline:	New Project; To be determined		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates on health department population and number of individuals actually agreeing to screening and further tests if warranted. Data Source: EHR or other documentation of patient population and agreement to participate in screening and education. Process Milestone 2 Estimated Incentive Payment: $95,686	**Outcome Improvement Target 1** [IT-1.13]: Diabetes care: Foot exam Improvement Target: [IT-1.13.a&b.] % TBD of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam Health Department Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment: $166,368	**Outcome Improvement Target 2** [IT-1.13]: Diabetes care: Foot exam Improvement Target: [IT-1.13.a&b.] % TBD of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam Health Department Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Administrative clinical data Outcome Improvement Target 2 Estimated Incentive Payment: $415,276	**Outcome Improvement Target 3** [IT-1.13]: Diabetes care: Foot exam Improvement Target: [IT-1.13.a&b.] % TBD of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam Health Department Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Administrative clinical data Outcome Improvement Target 3 Estimated Incentive Payment: $644,838
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $95,686	Year 3 Estimated Outcome Amount: $166,368	Year 4 Estimated Outcome Amount: $415,276	Year 5 Estimated Outcome Amount: $644,838
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,322,169			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique RHP outcome identification number(s): 136143806.3.9
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
Title of Outcome Measure (Improvement Target(s): IT-13.1 Pain Assessment

- **Outcome Measure Description:**

Pain is the biggest fear patients have when they are at the end of life; they want to be pain-free or at least have it managed at a tolerable level. Despite today's advances in medicine and technology, patients still suffer needlessly with uncontrolled pain when they are admitted to the hospital. The palliative care program will develop baseline information for pain on all palliative care patients which will include an evaluation of the presence of pain within 24 hours after receiving a palliative care screening request. If the patient is positive for pain, an in-depth evaluation of the pain will be done and a plan of care implemented to achieve pain control. The plan of care will be updated as needed based on pain levels the patient is experiencing. The use of rapid cycle improvement projects will allow us to see an increase of patients with controlled pain each year as we refine our protocols based on patient feedback.

- **Rationale:**

Advances in healthcare have led to great gains in technology and prolongation of life. Despite this fact, the healthcare industry continues to allow patients to suffer with uncontrolled pain while hospitalized. A report by the Institute of Medicine reported less than 50% of postoperative patients received adequate pain relief during their hospital stay (IOM, 2011). Cancer pain occurred in up to 90% of patients who had a recurrence of their disease, with 19% to 100% of these patients experiencing breakthrough pain (Hagen, Fisher, Victorino & Farrar, 2007). Quill, 2000, found 50% of conscious patients experienced moderate to severe pain in the last three days of life. MMH chose pain assessment as an improvement target because identification of patients who are experiencing pain is the first step of pain assessment. Undertreated or unrelieved pain causes. Anxiety, gait disturbances, slow rehabilitation, decreased socialization, depression, increased health care utilization and costs, and sleep disturbances (Zagaria, 2008). In order to avoid the negative consequences of pain and to improve quality of life, screening patients for pain is the first step in the process. Each consecutive year, the improvement target is to increase the number of patients who are assessed for pain. The goal is to see improvement each year so positive clinical outcomes are achieved. This will result in improved outcomes during the patient's hospitalization with decreased costs and increased patient satisfaction and improved quality of life which is in line with the regional goals.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Palliative Care project uses a method which ranks the importance of each project based several key factors. First, Midland considered the extent the

project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Midland considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Midland reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. For instance, this outcome domain is one of three outcome domains associated with Midland's palliative care project. Therefore, the value of this project varies in relation to the overall community benefit of the palliative care project. Palliative Care is an effective tool for meeting the needs of patient populations who are at risk of suffering from progressive illness. Studies have demonstrated that Palliative Care improves family satisfaction and patient quality of life while reducing symptom burden and costs associated with non-beneficial medical care. For this reason, many states are attempting to remedy the status quo through Palliative Care initiatives. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost savings, improved quality of life, and even prolongation of life. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial those savings can be used to further improve and expand supportive care for all patients.

References:

Hagen, N.A., Fisher, K., Victorino, C. & Farrar, J.T. (2007). A Titration Strategy is Needed to Manage Breakthrough Cancer Pain Effectively: Observation From Data Pooled From Three Clinical Trials. Journal of Palliative Medicine, 10(1), 47-55.

Institute of Medicine (2011). Relieving Pain In America: A Blueprint for Transforming Prevention,
Care, Education and Research. Washington, D.C.: The National Academies Press. Retrieved February 8, 2012 from http://www.iom.edu/Reports.aspx

Quill, T.E. (2000). Initiating End-of-Life Discussions with Seriously Ill Patients: Addressing the Elephant in the Room. The Journal of the American Medical Association, 284(19), 2502-2507.

Zagaria, M.A. (2008). Consequences of Pain. US Pharm, 33(5), 28-30.

136143806.3.9	***3.IT.13.1***	***Pain Assessment***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.2.3***		
Starting Point/Baseline:	***0 – Brand New 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)**
Process Milestone 1: P-2. During DY2, develop baseline information on number of palliative care patients who are screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Metric: P-2.1. Number of patients screened positive for pain; number of these patients whose clinical pain assessment occurred within 24 hours of screening. Data Source: P-2.1.a. EHR and Palliative Care database Process Milestone 2 Estimated Incentive Payment: $35,085	**Outcome Improvement Target 1** IT-13.1 Increase the number of palliative care patients that receive clinical assessments of pain within 24 hours of being screened positive for pain. Metric: IT-13.1.a&b. Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours <u>of screening positive for pain</u> Patients receiving palliative care who report pain when pain screening is done on the initial encounter Improvement Target: TBD% increase in number of patients clinical assessment within 24 hours of positive screen from base year rate. Data Source: IT-13.1.c. EHR and Palliative Care database	**Outcome Improvement Target 2** IT-13.1 Increase the number of palliative care patients that receive clinical assessments of pain within 24 hours of being screened positive for pain. Metric: IT-13.1.a&b. Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours <u>of screening positive for pain</u> Patients receiving palliative care who report pain when pain screening is done on the initial encounter Improvement Target: TBD% increase in number of patients clinical assessment within 24 hours of positive screen from base year rate. Data Source: IT-13.1.c. EHR and Palliative Care database	**Outcome Improvement Target 3** IT-13.1 Increase the number of palliative care patients that receive clinical assessments of pain within 24 hours of being screened positive for pain. Metric: IT-13.1.a&b. Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours <u>of screening positive for pain</u> Patients receiving palliative care who report pain when pain screening is done on the initial encounter Improvement Target: TBD% increase in number of patients clinical assessment within 24 hours of positive screen from base year rate. Data Source: IT-13.1.c. EHR and Palliative Care database

136143806.3.9	***3.IT.13.1***	***Pain Assessment***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.2.3***		
Starting Point/Baseline:	***0 – Brand New 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)**
	Outcome Improvement Target 1 Estimated Incentive Payment*:* $61,002	Outcome Improvement Target2 Estimated Incentive Payment*:* $152,268	Outcome Improvement Target 3 Estimated Incentive Payment*:* $236,441
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $35,085	Year 3 Estimated Outcome Amount: $61,002	Year 4 Estimated Outcome Amount: $152,268	Year 5 Estimated Outcome Amount: $236,441
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $484,795			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique RHP outcome identification number(s): 136143806.3.10
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
Title of Outcome Measure (Improvement Target(s): IT-13.2 Treatment Preferences

- **Outcome Measure Description:**

End-of-life will eventually be dealt with by all. This time can be characterized by severe emotional and spiritual distress. The palliative care program assists patients and families through this process. The palliative care program will determine if the palliative care patient has an advanced care directive in place that addresses life sustaining treatments. If there is an advance care directive, then the palliative care team will ensure all providers are aware of the patient's wishes. If an advance care directive is not in place, the palliative care coordinator will have social services discuss the matter with the patient and family. Information will be shared with patient and family and questions answered on the definition of life sustaining procedures and the options available to them so they have a full understanding of what it means to have an advanced care directive. If the patient or family does not have a desire for an advance care directive to be in place, then the wishes of the patient and family will be honored and it will be documented in the medical record. The palliative care program will work on increasing the number of patients with advance care directives in place each year.

- **Rationale:**

End of life discussions allow the patient/family to determine the goals and expectations they want to achieve near death. These discussions are difficult because so many do not want to accept the end of life is eventually going to occur. Healthcare providers are uncomfortable with speaking to the patient/family about plan of care when all hope seems gone. For this reason MMH chose improvement target Treatment Preferences in an effort to bring the patient's voice into the conversation (if they are unable to speak for themselves) and allow the family to know what the patient desired for the end of their life. An advance care directive allows this to occur. The advance care directive takes away the decision-making burden from the loved ones. When the patient's wishes were to have a peaceful death and aggressive care was done, this has an impact on quality of life. This can be the scenario if an advance care directive is not in place. Peereboom & Coycle, 2012, stated aggressive care was associated with decreased quality of life and poor bereavement adjustment for the caregivers. Wright, 2008, found caregivers of patients who received aggressive care were at higher risk for developing major depressive disorder and they were apt to feel less prepared for their loved one's death. Loved ones can feel guilty when faced with making the decision to stop life-sustaining support. It is important for the palliative care team to address this issue. The palliative care team will address an advance directive with the patient and family if one is not in place. If the patient is incapacitated and there is not an advance directive in place, a family meeting will be held to discuss the resuscitation status and wishes of the patient/family. The goal will be a consensus

among family members. Each consecutive year, the improvement target is to increase the number of patients who have documentation of treatment preferences for life sustainment. The goal is to see improvement each year so positive clinical outcomes are achieved. This will result in improved outcomes during the patient's hospitalization with decreased costs and increased patient satisfaction. The regional goal of improving cost-effectiveness is met in this target.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Palliative Care project uses a method which ranks the importance of each project based several key factors. First, Midland considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Midland considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Midland reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. For instance, this outcome domain is one of three outcome domains associated with Midland's palliative care project. Therefore, the value of this project varies in relation to the overall community benefit of the palliative care project. Palliative Care is an effective tool for meeting the needs of patient populations who are at risk of suffering from progressive illness. Studies have demonstrated that Palliative Care improves family satisfaction and patient quality of life while reducing symptom burden and costs associated with non-beneficial medical care. For this reason, many states are attempting to remedy the status quo through Palliative Care initiatives. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost savings, improved quality of life, and even prolongation of life. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial those savings can be used to further improve and expand supportive care for all patients.

References:

Peereboom, K. & Coyle, N. (2012). Facilitating Goals of Care Discussions for Patients with Life-limiting Disease, Communication Strategies For Nurses. Journal of Hospice and Palliative Nursing, 14(4), 251-258.
Wright, A.A., Zhang, B., Ray, A., Mack, J.W., Trice, E., Balboni, T., Mitchell, S.L., Jackson, V.A., Block, S.D., Maciejewski, P.K., & Prigerson, H.G. (2008). Association Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment. The Journal of the American Medical Association, 300(14), 1665-1673.

136143806.3.10	***3.IT.13.2***	***Treatment Preference***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.2.3***		
Starting Point/Baseline:	***0 – Brand New 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)**
Process Milestone 1: P-2. During DY2, develop baseline information on the percentage of patients with chart documentation of preferences for life sustaining treatments. Metric: Number of patients whose medical record includes documentation of life sustaining preferences. Data Source: EHR and Palliative Care database Process Milestone 2 Estimated Incentive Payment: $35,085	**Outcome Improvement Target 1** IT-13.2 Increase the number of palliative care patients with chart documentation of preferences for life sustaining treatments. Metric: IT-13.2.a&b. Patients with medical records including documentation of life sustaining preferences Seriously ill patients receiving palliative care in our hospital Improvement Target: TBD% increase of patients with chart documentation of life sustaining treatment preferences over baseline year. Data Source: EHR and Palliative Care database Outcome Improvement Target 1 Estimated Incentive Payment*:* $61,002	**Outcome Improvement Target 2** IT-13.2 Increase the number of palliative care patients with chart documentation of preferences for life sustaining treatments. Metric: IT-13.2.a&b. Patients with medical records including documentation of life sustaining preferences Seriously ill patients receiving palliative care in our hospital Improvement Target: TBD% increase of patients with chart documentation of life sustaining treatment preferences over baseline year. Data Source: EHR and Palliative Care database Outcome Improvement Target21 Estimated Incentive Payment*:* $152,268	**Outcome Improvement Target 3** IT-13.2 Increase the number of palliative care patients with chart documentation of preferences for life sustaining treatments. Metric: IT-13.2.a&b. Patients with medical records including documentation of life sustaining preferences Seriously ill patients receiving palliative care in our hospital Improvement Target: TBD% increase of patients with chart documentation of life sustaining treatment preferences over baseline year. Data Source: EHR and Palliative Care database Outcome Improvement Target 3 Estimated Incentive Payment*:* $236,441
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $35,085	Year 3 Estimated Outcome Amount: $61,002	Year 4 Estimated Outcome Amount: $152,268	Year 5 Estimated Outcome Amount: $236,441

136143806.3.10	*3.IT.13.2*	*Treatment Preference*	
Midland Memorial Hospital			*136143806*
Related Category 1 or 2 Projects:	*136143806.2.3*		
Starting Point/Baseline:	*0 – Brand New 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $484,795			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique RHP outcome identification number(s): 136143806.3.11
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
Title of Outcome Measure (Improvement Target(s) : IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregivers did not want to discuss.

- **Outcome Measure Description:**

A patient's spiritual and religious beliefs play very important roles in palliative care. The spiritual aspect of a patient is one of the domains the palliative care program evaluates. The palliative care program will evaluate the spiritual needs the patient may have upon admission to the program. The evaluation will consist of religious preferences, church affiliations, special considerations and cultural practices that are important to the patient and family. The palliative care program expects to see the percentage of patients with documentation in the medical record to increase each year.

- **Rationale:**

Individuals with life-threatening illness frequently struggle with fear, anger, physical discomfort, loss of independence, and troubling spiritual questions, as well as changing self-image, roles and relationships. MMH chose to address spiritual/religious concerns because one's spiritual or religious beliefs and practices may have a profound impact on how the individual copes with suffering that so often accompanies advanced disease." (Hills, Paice, Cameron & Shott, 2005). It is important for the palliative care team to meet these needs of the patient as they approach end of life so they have a peaceful death. Spiritual concerns are also important for family members, helping them to come to terms with the loss of their loved one. A patient's psychosocial and spiritual values affect how they respond to care received in the hospital. Improving spirituality has been shown to be associated with decreased anxiety and depression, reduced mortality rates among cancer patients and improved clinical outcomes such as improved pain and reduced length of stay (Clark, Drain & Malone, 2003). Each consecutive year the improvement target is to increase the number of patients with chart documentation of spiritual/religious concerns. The goal is to see improvement each year so positive clinical outcomes such as decreased anxiety and depression can be achieved. This improvement target meets the regional goal of improved quality of care.

- **Outcome Measure Valuation:**

The valuation of Midland Memorial's Palliative Care project uses a method which ranks the importance of each project based several key factors. First, Midland considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b)

increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Midland considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Midland reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. For instance, this outcome domain is one of three outcome domains associated with Midland's palliative care project. Therefore, the value of this project varies in relation to the overall community benefit of the palliative care project. Palliative Care is an effective tool for meeting the needs of patient populations who are at risk of suffering from progressive illness. Studies have demonstrated that Palliative Care improves family satisfaction and patient quality of life while reducing symptom burden and costs associated with non-beneficial medical care. For this reason, many states are attempting to remedy the status quo through Palliative Care initiatives. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost savings, improved quality of life, and even prolongation of life. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial those savings can be used to further improve and expand supportive care for all patients.

References:

Clark, P.A., Drain, M., & Malone, M.P. (2003). Addressing Patient's Emotional and Spiritual Needs.
Joint Commission Journal of Quality and Safety. 29(12), 659-670.

Hills, J., Paice, J.A., Cameron, J.R. & Shott, S. (2005). Spirituality and Distress in Palliative Care Consultation. Journal of Palliative Medicine, 8(4), 782-788.

136143806.3.11	*3.IT.13.5*	*Documentation of Spiritual/Religious Concerns*	
Midland Memorial Hospital			*136143806*
Related Category 1 or 2 Projects:	*136143806.2.3*		
Starting Point/Baseline:	*0 – Brand New 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)**
Process Milestone 1: P-2. During DY2, develop baseline information on number of palliative care patients with whom a discussion of their spiritual/religious concerns is documented in the clinical record. Metric: Number of patients queried about spiritual/religious concerns and said information documented in clinical record. Data Source: EHR and Palliative Care database Process Milestone 2 Estimated Incentive Payment: $35,085	**Outcome Improvement Target 1** IT-13.2. Increase the number of palliative care patients with chart documentation of discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. Metric: IT-13.2.a&b. Patients with chart documentation of spiritual/religious concerns or documentation that the patient/ family did not want to discuss Total number of patients discharged from palliative care during the designated reporting period. Improvement Target: TBD% increase of the number of patients with chart documentation of spiritual/religious concerns or desire not to discuss over baseline year. Data Source: IT-13-5.c EHR and Palliative Care database	**Outcome Improvement Target 2** IT-13.2. Increase the number of palliative care patients with chart documentation of discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. Metric: IT-13.2.a&b. Patients with chart documentation of spiritual/religious concerns or documentation that the patient/ family did not want to discuss Total number of patients discharged from palliative care during the designated reporting period. Improvement Target: TBD% increase of the number of patients with chart documentation of spiritual/religious concerns or desire not to discuss over baseline year Data Source: IT-13-5.c EHR and Palliative Care database	**Outcome Improvement Target 3** IT-13.2. Increase the number of palliative care patients with chart documentation of discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. Metric: IT-13.2.a&b. Patients with chart documentation of spiritual/religious concerns or documentation that the patient/ family did not want to discuss Total number of patients discharged from palliative care during the designated reporting period. Improvement Target: TBD% increase of the number of patients with chart documentation of spiritual/religious concerns or desire not to discuss over baseline year Data Source: IT-13-5.c EHR and Palliative Care database

136143806.3.11	***3.IT.13.5***	***Documentation of Spiritual/Religious Concerns***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects:	***136143806.2.3***		
Starting Point/Baseline:	***0 – Brand New 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)**
	Outcome Improvement Target 1 Estimated Incentive Payment*:* $61,002	Outcome Improvement Target21 Estimated Incentive Payment*:* $152,268	Outcome Improvement Target 3 Estimated Incentive Payment*:* $236,441
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $35,085	Year 3 Estimated Outcome Amount: $61,002	Year 4 Estimated Outcome Amount: $152,268	Year 5 Estimated Outcome Amount: $236,441
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $484,795			

Category 3 Unique Project ID/Outcome Measure and Performing Provider

Unique Project ID: 136143806.3.12
Performing Provider Name/TPI: Midland Memorial Hospital / 136143806
Title of Outcome Measure (Improvement Target): IT-11.1- Improvement in Clinical Indicator in Identified Disparity Group: Prenatal Care and Low Income Women of Childbearing Age

- **Outcome Measure Description:**

Over the course of the next 5 years, we will create a system in which low income women of childbearing age will be targeted and tracked to improve their health education and awareness thus impacting the findings of the most recent community health needs assessment showing that this targeted population is more likely to misuse the ED, be uninsured and not manage chronic or preventable health disorders which would result in a failure to seek prenatal care.

- **Rationale:**

According to the Texas Health and Human Service Commission, our region, compared to the US has higher percentages of individuals who say they cannot access healthcare due to cost. Additionally in our region, those classified as low income women are shown to be more likely than their counterparts to report they cannot access healthcare due to cost. Furthermore, according to the Texas Behavioral Risk Factor Surveillance System, this same population (low income women), are more likely than their counterparts to report that they are uninsured and less likely to have routine health screenings and use other preventative health services. Since access to health care is important to the quality of healthcare outcomes, individuals who access the various healthcare services in the most appropriate fashion are more likely to avoid preventable disease processes, manage common health disorders more effectively as well as manage their healthcare costs. If we can target this population identified as at risk in this area, and better educate them on basic health information including how to access the most cost effective healthcare services, we will provide them with the tools to improve their health and the health of their families while decreasing inappropriate use of the ED and the resulting financial burden on the hospital district.

- **Outcome Measure Valuation:**

The valuation of each MMH project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Patients, especially those that can be categorized as “at risk,” need access to preventative care in order to avoid and/or track the onset of chronic diseases, which will ultimately lead to better patient outcomes and fewer preventable hospital admissions down the line. The continually increasing number of uninsured and underinsured patients presenting to our ED for primary care or potentially preventable diseases has created a financial burden on the hospital district, in addition to resulting in suboptimal patient outcomes.

Women are particularly at risk in the absence of appropriate healthcare options and ongoing care. Focusing on low income women for more regular treatment will help MMH produce a more valuable use of time and funds for the benefit realized because of reduced reliance on ED treatment and better overall health outcomes.

136143806.3.12	***3.IT-11.1***	***Improvement in Clinical Indicator in identified disparity group***	
Midland Memorial Hospital			***136143806***
Related Category 1 or 2 Projects::	***136143806.2.4***		
Starting Point/Baseline:	***To be determined.***		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2] Establish baseline rates. By the end of DY2, we will have created a system by which the appropriate data can be collected in the ED and used as a baseline to measure improvement. Metric: Documentation of the data collection method and development of baseline data. Data Source: EHR & Claims Process Milestone 1 Estimated Incentive Payment: $114,823	Outcome Improvement Target 1 [I-T-11.1] Improvement in Clinical Indicator in identified disparity group. Target: Decrease the percentage of low income women that presents to hospital with no prenatal care by TBD%. Metric: percentage of low income women who present to the hospital in labor who have no prenatal care. # of low income women presenting to in labor with no history of prenatal care Total # of low income deliveries Data Source: Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $199,642	Outcome Improvement Target 2 [I-T-11.1] Improvement in Clinical Indicator in identified disparity group. Target: Decrease the percentage of low income women that presents to hospital with no prenatal care by TBD%. Metric: percentage of low income women who present to the hospital in labor who have no prenatal care. # of low income women presenting in labor with no history of prenatal care Total # of low income deliveries Data Source: Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $498,331	Outcome Improvement Target 3 [I-T-11.1] Improvement in Clinical Indicator in identified disparity group. Target: Decrease the percentage of low income women that presents to hospital with no prenatal care by TBD%. Metric: percentage of low income women who present to the hospital in labor who have no prenatal care. # of low income women presenting in labor with no history of prenatal care Total # of low income deliveries Data Source: Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $773,806
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $114,823	Year 3 Estimated Outcome Amount: $199,642	Year 4 Estimated Outcome Amount: $498,331	Year 5 Estimated Outcome Amount: $773,806
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,586,602			

Title of Outcome Measure (Improvement Target): IT-2.4- Behavioral Health/Substance Abuse (BH/SA) Admission Rate
Unique RHP outcome identification number (s): 081939301.3.1/ Texas Tech University Health Sciences Center - 081939301
Outcome Measure Description:
IT- 2.4- Behavioral Health/Substance Abuse (BH/SA) Admission Rate

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 base line rates

Outcome Improvement targets for each year:

- DY4:
    - IT-2.4: Reduce behavioral health admissions by a 3% over baseline
- DY5:
    - IT-2.4: Reduce behavioral health admissions by a 5% over baseline

Rationale:

Process milestones P-1 and P-2 were chosen so we could create an implementation plan and then establish baseline rates upon which to improve. Improvement targets were chosen so we could measure the percentage of admissions and reduce that percentage with our increased access to care. In FY12 there were 124 hospital admissions, by the end of DY5 we hope to reduce that number by 5%.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.1	*3.IT 2.4*	*Behavioral Health/Substance Abuse(BH/SA)Admission Rate*	
Texas Tech University Health Sciences Center			*081939301*
Related Category 1 or 2 Projects:	*081939301.1.1-Expansion of Behavioral Health Services*		
Starting Point/Baseline:	*Baseline TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P-1*]: Project Planning- identify current capacity and needed resources for provider recruitment Data Source: project planning documents Process Milestone 1 Estimated Incentive Payment*:* $41,689	**Process Milestone 2 [P-2]:**Establish baseline rates for reporting on patient numbers Data Source: EMR Process Milestone 2 Estimated Incentive Payment: $96,645	**Outcome Improvement Target 1** [IT-2.4]: Improvement Target: Reduce behavioral health admissions by 3% over baseline established in DY3 Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $103,388	**Outcome Improvement Target 2** [IT-2.4]: Improvement Target: Reduce behavioral health admissions by 5% over baseline established in DY3 Data Source: EMR Outcome Improvement Target 2Estimated Incentive Payment*:* $224,756
Year 2 Estimated Outcome Amount: $41,689	Year 3 Estimated Outcome Amount: $96,645	Year 4 Estimated Outcome Amount: $103,388	Year 5 Estimated Outcome Amount: $224,756
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $466,478			

Title of Outcome Measure (Improvement Target): IT-6.1 – Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number (s): 081939301.3.2/Texas Tech University Health Sciences Center/ 081939301

Outcome Measure Description:

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

- Patient satisfaction with receiving 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
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders
- DY3:
    - P-3: Develop and test data systems
    - P-2: Establish base line rates

Outcome Improvement targets for each year:

- DY4:
    - IT-6.1: Increase percentage of patient satisfaction with receiving timely care, appointments, and information over baseline by 7%
- DY5:
    - IT-6.1: Increase percentage of patient satisfaction with receiving timely care, appointments, and information over baseline by 10%

Rationale:

Process milestones P-1, P-2, P-3 and P-5 were chosen due to TTUHSC Permian Basin not currently having a measure in place to determine patient satisfaction. In order to accurately gather and report data these process milestones must be approached in DY2 – DY3.

Improvement target was chosen so we could measure the percentage of improvement for patient satisfaction. By expanding primary care access we should see an increase in patient satisfaction with the timeliness of care, appointment and information.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Texas Tech University Health Sciences Center			*[RHP Performing Provider - TPI]*
Related Category 1 or 2 Projects:	*081939301.1.2-VIP Relationships in the Patient Home*		
Starting Point/Baseline:	*Baseline to be determined 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- project coordination and set up Data Source: project planning documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $20,391 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders Data Source: meeting notes showing findings and best practices during planning and set up Process Milestone 2 Estimated Incentive Payment: $20,391	**Process Milestone 3** [*P-3*]: Develop and test data systems Data Source: reports showing test results Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $47,272 **Process Milestone 4** [P-2]: Establish baseline rates Data Source: baseline results Process Milestone 4 Estimated Incentive Payment: $47.272	**Outcome Improvement Target 1** [IT-6.1]: Improvement Target: 7% improvement over baseline scores based on (1) are getting timely care, appointments, and information Data Source: survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $101,140	**Outcome Improvement Target 2** [IT-6.1]: Improvement Target: 10% improvement over baseline scores based on (1) are getting timely care, appointments, and information Data Source: survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $219,870
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $40,782	Year 3 Estimated Outcome Amount: $94,544	Year 4 Estimated Outcome Amount: $101,140	Year 5 Estimated Outcome Amount: $219,870

081939301.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Texas Tech University Health Sciences Center			*[RHP Performing Provider - TPI]*
Related Category 1 or 2 Projects:	*081939301.1.2-VIP Relationships in the Patient Home*		
Starting Point/Baseline:	*Baseline to be determined 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $456,336			

Title of Outcome Measure (Improvement Target): IT-9.2- ED Appropriate Utilization
Unique RHP outcome identification number (s): 081939301.3.3/Texas Tech University Health Sciences Center 081939301
Outcome Measure Description:
IT-9.2: ED Appropriate Utilization – overall visits

Process Milestones:

- DY2:
    - P-1: Project planning – engage stakeholders, identify current capacity, and needed resources, determine timelines and document implementation plans
- DY3:
    - P-2: Establish baseline rates

Outcome Improvement targets for each year:

- DY4:
    - IT-9.2 – Reduce ED visits by a TBD% over baseline
- DY5:
    - IT-9.2- Reduce ED visits by a TBD% over baseline

Rationale:

Process milestones P-1, and P-2 were chosen so we could create an implementation plan and then establish baseline rates upon which to improve. Improvement targets were chosen so we could measure the percentage of ED visits in the rural areas and reduce them by a TBD%. This is a brand new initiative for TTUHSC. We are creating a new rural track program for residents in order to better train them in rural medicine as well as encourage them to practice rural medicine. This will create better access to primary care in these rural areas and therefore reduce unnecessary ED visits. In DY2 and DY3 we will be gathering data and forming plans in order to track ED usage in these rural areas. In DY4 and DY5 we plan to reduce ED utilization by a TBD%.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,

- Population served and
- Project Investment.

081939301.3.3	*3.IT 9.2*	*ED Appropriate Utilization*	
Texas Tech University Health Sciences Center			*081939301*
Related Category 1 or 2 Projects:	*081939301.1.3-Family Medicine Rural Track*		
Starting Point/Baseline:	*Baseline will be established 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: project implementation documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $48,939	**Process Milestone 2** [P-2]: Establish base line rates for ED utilization Data Source: reports from participating hospitals Process Milestone 3 Estimated Incentive Payment: $113,453	**Outcome Improvement Target 1** [IT-9.2]: Improvement Target: Reduce ED visits by a TBD% Data Source: reports from participating hospitals Outcome Improvement Target 1 Estimated Incentive Payment*:* $121,368	**Outcome Improvement Target 2** [IT-9.2]: Improvement Target: Reduce ED visits by a TBD% Data Source: reports from participating hospitals Outcome Improvement Target 2Estimated Incentive Payment*:* $263,844
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,939	Year 3 Estimated Outcome Amount: $113,453	Year 4 Estimated Outcome Amount: $121,368	Year 5 Estimated Outcome Amount: $263,844
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $547,604			

Title of Outcome Measure (Improvement Target): IT-12.1 – Breast Cancer Screening

Unique RHP outcome identification number (s): 081939301.3.4/Texas Tech University Health Sciences Center 081939301

Outcome Measure Description:
IT- 12.1 – Percent improvement of women receiving breast cancer screenings

- By expanding primary care access we hope to increase the screening women receive and catch problems earlier

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 base line rates
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement targets for each year:

- DY4:
    - IT-12.1: Increase percentage of women receiving breast cancer screenings by 5% over baseline
- DY5:
    - IT-12.1: Increase percentage of women receiving breast cancer screenings by 7% over baseline

Rationale:

Process milestones P-1, P-2, and P-5 were chosen in order to allow TTUHSC-PB to create a plan and implement it, in order to accurately gather and report data. These process milestones must be approached in DY2 – DY3.

Improvement targets were chosen so we could measure the percentage of patients with improved screening access.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.4	*3.IT.12.1*	*Primary Care and Prevention*	
Texas Tech University Health Sciences Center-PB			*081939301*
Related Category 1 or 2 Projects:	*081939301.1.4*		
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, needed resources, determine timelines and document implementation plans Data Source: competed strategic plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,990	**Process Milestone 2** [P-2]: Establish base line rates Data Source: IDX reports Process Milestone 2 Estimated Incentive Payment: $15, 057 **Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders Data Source: progress reports Process Milestone 3 Estimated Incentive Payment: $15,057	**Outcome Improvement Target 1** [IT-12.1]: Breast cancer screening Improvement Target: 5% over baseline improvement in women receiving breast cancer screenings Data Source: EMR Estimated incentive payment$32,215	**Outcome Improvement Target 1** [IT-12.1]: Breast cancer screening Improvement Target: 7% improvement over baseline women receiving breast cancer screenings Data Source: EMR Estimate incentive payment:$70,032
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $12,990	Year 3 Estimated Outcome Amount: $30,114	Year 4 Estimated Outcome Amount: $32,215	Year 5 Estimated Outcome Amount: $70,032
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $145,351			

Title of Outcome Measure (Improvement Target): IT-12.2 – Cervical Cancer Screening

Unique RHP outcome identification number (s): 081939301.3.5/ Texas Tech University Health Sciences Center 081939301

Outcome Measure Description:
IT- 12.2 – Percent improvement of women receiving cervical cancer screenings

- By expanding primary care access we hope to increase the screening women receive and catch problems earlier

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 base line rates
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement targets for each year:

- DY4:
    - IT-12.2: Increase percentage of women receiving cervical cancer screenings by 5% over baseline
- DY5:
    - IT-12.2: Increase percentage of women receiving cervical cancer screenings by 7% over baseline

Rationale:

Process milestones P-1, P-2, and P-5 were chosen in order to allow TTUHSC-PB to create a plan and implement it, in order to accurately gather and report data. These process milestones must be approached in DY2 – DY3.

Improvement targets were chosen so we could measure the percentage of patients with improved screening access.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.5	*3.IT.12.2*	*Primary Care and Prevention*	
Texas Tech University Health Sciences Center-PB			*081939301*
Related Category 1 or 2 Projects:	*081939301.1.4*		
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, needed resources, determine timelines and document implementation plans Data Source: competed strategic plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,990	**Process Milestone 2** [P-2] Establish base line rates Data Source: IDX reports Process Milestone 2 Estimated Incentive Payment: $15, 057 **Process Milestone 3** [P-5] Disseminate findings, including lessons learned and best practices to stakeholders Data Source: progress reports Process Milestone 3 Estimated Incentive Payment: $15,057	**Outcome Improvement Target 1** [IT-12.2]: Cervical cancer screening Improvement Target: 5% over baseline improvement in women receiving cervical cancer screenings Data Source: EMR Estimated incentive payment$32,215	**Outcome Improvement Target 1** [IT-12.2]: Cervical cancer screening Improvement Target: 7% improvement over baseline women receiving cervical cancer screenings Data Source: EMR Estimate incentive payment:$70,033
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $12,990	Year 3 Estimated Outcome Amount: $30,114	Year 4 Estimated Outcome Amount: $32,215	Year 5 Estimated Outcome Amount: $70,033
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $145,352			

Title of Outcome Measure (Improvement Target): IT-12.5: Second Teen Pregnancy

Unique RHP outcome identification number (s): 081939301.3.6/Texas Tech University Health Sciences Center 081939301

Outcome Measure Description:
IT- 12.5 – Percent reduction in second teen pregnancy

- By expanding primary care access we hope to decrease the number of second teen pregnancies

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 base line rates
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement targets for each year:

- DY4:
    - IT-12.5: TBD% reduction in baseline in second teen pregnancies
- DY5:
    - IT-12.5: TBD% reduction in baseline in second teen pregnancies

Rationale:

Process milestones P-1, P-2, and P-5 were chosen in order to allow TTUHSC-PB to create a plan and implement it, in order to accurately gather and report data. These process milestones must be approached in DY2 – DY3.

Improvement targets were chosen so we could measure the percentage of teenagers with second pregnancies

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.6	*3.IT.12.5*	*Primary Care and Prevention*	
Texas Tech University Health Sciences Center-PB			*081939301*
Related Category 1 or 2 Projects:	*081939301.1.4*		
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, needed resources, determine timelines and document implementation plans Data Source: competed strategic plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,990	**Process Milestone 2** [P-2] Establish base line rates Data Source: IDX reports Process Milestone 2 Estimated Incentive Payment: $15, 057 **Process Milestone 3** [P-5] Disseminate findings, including lessons learned and best practices to stakeholders Data Source: progress reports Process Milestone 3 Estimated Incentive Payment: $15,057	**Outcome Improvement Target 1** [IT-12.5]: Second teen pregnancy Improvement Target: TBD% reduction in baseline in second teen pregnancy Data Source: EMR Estimated incentive payment$32,215	**Outcome Improvement Target 1** [IT-12.5]: Second teen pregnancy Improvement Target: TBD% reduction in second teen pregnancy Data Source: EMR Estimate incentive payment:$70,033
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $12,990	Year 3 Estimated Outcome Amount: $30,114	Year 4 Estimated Outcome Amount: $32,215	Year 5 Estimated Outcome Amount: $70,033
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $145,352			

Title of Outcome Measure (Improvement Target): IT-1.11- Diabetes Care (<140/80mm Hg)
Unique RHP outcome identification number (s): 081939301.3.7/Texas Tech University Health Sciences Center 081939301
Outcome Measure Description:
IT- 1.11- Diabetes Care (<140/80mm Hg)
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 base line rates

Outcome Improvement targets for each year:

- DY4:
    - IT-1.11- Reduce % of patients that have BP <140/80mm Hg by 5% over baseline
- DY5:
    - IT-1.11 – Reduce % of patients that have BP <140/80mm Hg by 10% over baseline

Rationale:

Process milestones P-1 and P-2 were chosen so we could create an implementation plan and then establish baseline rates upon which to improve. Improvement targets were chosen so we could measure the percentage of reduction with patients that have high blood pressure and reduce that % by a TBD amount.

Outcome Measure Valuation:
Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.7	*3.IT 1.11*	*Diabetes Care: BP Control (<140/80mm Hg)*	
Texas Tech University Health Sciences Center			*081939301*
Related Category 1 or 2 Projects:	*081939301.2.1-Diabetes Coordinated Care (DCC) Center*		
Starting Point/Baseline:	*Baseline will be established 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 Data Source: Project Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,376	**Process Milestone 2** [P- 2]: Establish base line rates Data Source: patient registry Process Milestone 3 Estimated Incentive Payment: $81,938	**Outcome Improvement Target 1** [IT-1.11]: Improvement Target: Reduce % of patients that have BP <140/80mm Hg by 5% over baseline Data Source: patient registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $87,655	**Outcome Improvement Target 2** [IT-1.11]: Improvement Target: Reduce % of patients that have BP <140/80mm Hg by 10% over baseline Data Source: patient registry Outcome Improvement Target 2 Estimated Incentive Payment*:* $190,554
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $35,345	Year 3 Estimated Outcome Amount: $81,938	Year 4 Estimated Outcome Amount: $87,655	Year 5 Estimated Outcome Amount: $190,554
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $395,492			

Title of Outcome Measure (Improvement Target): IT-1.10- Diabetes Care – HbA1C poor control

Unique RHP outcome identification number (s): 081939301.3.8/Texas Tech University Health Sciences Center 081939301

Outcome Measure Description:

IT- 1.10 – Diabetes Care – HbA1C poor control

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 base line rates
    - P-3: Develop and test data systems; determine best practices for data gathering

Outcome Improvement targets for each year:

- DY4:
    - IT-1.10- Reduce the % of patients with HbA1C >9.0% by 7% over baseline
- DY5:
    - IT-1. 10- Reduce the % of patients with HbA1C >9.0% by 10% over baseline

Rationale:

Process milestones P-1, P-2 and P-3 were chosen so we could create an implementation plan test the system and then establish baseline rates upon which to improve. Improvement targets were chosen so we could measure the percentage of reduction with patients that have poorly controlled HbA1C levels >9.0%. The Department of Internal Medicine provides care to a significant number of underinsured and uninsured patients within RHP 14. This population of patients, often times do not have access to quality medical care. The community delivers health care to an increasing number of people with limited budget resources. The University is a state entity caring for many Medicaid and Medicare recipients and MCH is the tertiary county hospital with emphasis on caring for these people. Our proposal targets management of at-risk persons and people with diabetes to prevent the progression of pre-diabetes, delay end-organ complications of diabetes and reduce hospital re-admissions.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.8	*3.IT-1.10*	*Diabetes Care – HbA1C poor control*	
Texas Tech University Health Sciences Center			*081939301*
Related Category 1 or 2 Projects:	*081939301.2.2/New model for delivery of diabetes care in the outpatient clinic*		
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 Data Source: project plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,376	**Process Milestone 2** [P-2] Establish baseline rates Data Source: EMR Process Milestone 2 Estimated Incentive Payment: $29,413 **Process Milestone 3** [P-3] Develop and test data systems; determine best practices for data gathering Data Source: EMR Process Milestone 3 Estimated Incentive Payment: $29,412	**Outcome Improvement Target 1** [IT-1.10]: Improvement Target: Diabetes Care – HbA1c poor control (>9.0%)-reduction in number of patients with HbA1c levels >9.0% by 7% Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $62,932	**Outcome Improvement Target 2** [IT-1.10]: Improvement Target: Diabetes Care – HbA1c poor control (>9.0%)-reduction in number of patients with HbA1c levels >9.0% by 10% Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $136,808
Year 2 Estimated Outcome Amount: $25,376	Year 3 Estimated Outcome Amount: $58,827	Year 4 Estimated Outcome Amount: $62,932	Year 5 Estimated Outcome Amount: $136,808
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $283,943			

Title of Outcome Measure (Improvement Target): IT-3.3- Diabetes 30 day readmission rate

Unique RHP outcome identification number (s): 081939301.3.9/ Texas Tech University Health Sciences Center/081939301

Outcome Measure Description:
IT- 3.3- Diabetes 30 day readmission rate
Process Milestones:

- DY2:
    - P-1: Project planning – engage stakeholders, identify current capacity, and needed resources, determine timelines and document implementation plans
- DY3:
    - P-1: Project planning- engage stakeholders, identify current capacity, and needed resources, determine timeline and document implementation plans
    - P-2: Establish baseline rates

Outcome Improvement targets for each year:

- DY4:
    - IT-3.3- Reduce diabetes readmission rate by 10% of baseline
- DY5:
    - IT-3.3 – Reduce diabetes readmission rate by 15% of baseline

Rationale:

Process milestones P-1, and P-2 were chosen so we could create an implementation plan and then establish baseline rates upon which to improve. Improvement targets were chosen so we could measure the percentage of diabetes readmission rates and reduce that by 7% in DY5.

Outcome Measure Valuation:
Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,

- Population served and
- Project Investment.

081939301.3.9	*3.IT 3.3*	*Diabetes 30 day readmission rate*	
Texas Tech University Health Sciences Center			*081939301*
Related Category 1 or 2 Projects:	*081939301.2.3*		
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-Link TTHSC to MCH along with other outpatient providers to provide coordinated care Data Source: documentation of plan Process Milestone 1 Estimated Incentive Payment: $17,219	**Process Milestone 2** [P-1]: Project planning- Develop referral system to coordinate care Data Source: referral system Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $19,959 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: report from participating hospital Process Milestone 3 Estimated Incentive payment:$19,960	**Outcome Improvement Target 1** [IT-3.3]: Improvement Target: Diabetes 30 day readmission rate Goal: reduce by 10% over baseline Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $42,704	**Outcome Improvement Target 2** [IT-3.3]: Improvement Target: Diabetes 30 day readmission rate Goal: reduce by 15% over baseline Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $92,834
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $17,219	Year 3 Estimated Outcome Amount: $39,919	Year 4 Estimated Outcome Amount: $42,704	Year 5 Estimated Outcome Amount: $92,834
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $192,676			

Title of Outcome Measure (Improvement Target): IT-12.1 – Breast Cancer Screening
Unique RHP outcome identification number (s): 081939301.3.10/Texas Tech University Health Sciences Center 081939301
Outcome Measure Description:
IT- 12.1 – Percent improvement of women receiving breast cancer screenings

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 base line rates
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement targets for each year:

- DY4:
    - IT-12.1: Increase percentage of women receiving breast cancer screenings by 3% over baseline
    - IT-12.2:Increase percentage of women receiving cervical cancer screenings by 3% over baseline
    - IT-12.5: Reduction in percentage of second teen pregnancies by 3% over baseline
- DY5:
    - IT-12.1: Increase percentage of women receiving breast cancer screenings by 5% over baseline
    - IT-12.2:Increase percentage of women receiving cervical cancer screenings by 5% over baseline
    - IT-12.5: Reduction in percentage of second teen pregnancies by 5% over baseline

Rationale:

Process milestones P-1, P-2, and P-5 were chosen in order to allow TTUHSC-PB to create a plan and implement it, in order to accurately gather and report data. These process milestones must be approached in DY2 – DY3.

Improvement targets were chosen so we could measure the percentage of patients with improved screening access.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.10	*3.IT-12.1*	*Primary Care and Prevention*	
Texas Tech University Health Sciences Center-PB			*081939301*
Related Category 1 or 2 Projects:	*081939301.2.4*		
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, needed resources, determine timelines and document implementation plans Data Source: competed strategic plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $4.833	**Process Milestone 2** [P-2] Establish base line rates Data Source: strategic plan Process Milestone 3 Estimated Incentive Payment: $5.602 **Process Milestone 2** [P-5] Disseminate findings, including lessons learned and best practices to stakeholders Data Source: strategic plan Process Milestone 4 Estimated Incentive Payment: $5,603	**Outcome Improvement Target 1** [IT-12.1]: Breast cancer screening Improvement Target: 3% over baseline improvement in women receiving breast cancer screenings Data Source: EMR Estimated incentive payment:$11,987	**Outcome Improvement Target 4** [IT-12.1]: Breast cancer screening Improvement Target: 5% improvement over baseline women receiving breast cancer screenings Data Source: EMR Estimated incentive payment:$26,058
Year 2 Estimated Outcome Amount: $4,833	Year 3 Estimated Outcome Amount: $11,205	Year 4 Estimated Outcome Amount: $11,987	Year 5 Estimated Outcome Amount: $26,058
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $54,083			

Title of Outcome Measure (Improvement Target): IT-12.2 – Cervical Cancer Screening
Unique RHP outcome identification number (s): 081939301.3.11/Texas Tech University Health Sciences Center 081939301
Outcome Measure Description:
IT- 12.2 – Percent improvement of women receiving cervical cancer screenings

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 base line rates
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement targets for each year:

- DY4:
    - IT-12.2:Increase percentage of women receiving cervical cancer screenings by 3% over baseline
- DY5:
    - IT-12.2:Increase percentage of women receiving cervical cancer screenings by 5% over baseline

Rationale:

Process milestones P-1, P-2, and P-5 were chosen in order to allow TTUHSC-PB to create a plan and implement it, in order to accurately gather and report data. These process milestones must be approached in DY2 – DY3.

Improvement targets were chosen so we could measure the percentage of patients with improved screening access.

Outcome Measure Valuation:
Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,

- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.11	*3.IT-12.2*	*Primary Care and Prevention*	
Texas Tech University Health Sciences Center-PB			*081939301*
Related Category 1 or 2 Projects:	*081939301.2.4*		
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, needed resources, determine timelines and document implementation plans Data Source: competed strategic plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,834	**Process Milestone 2** [P-2] Establish base line rates Data Source: strategic plan Process Milestone 3 Estimated Incentive Payment: $5.602 **Process Milestone 2** [P-5] Disseminate findings, including lessons learned and best practices to stakeholders Data Source: strategic plan Process Milestone 4 Estimated Incentive Payment: $5,603	**Outcome Improvement Target 1** [IT-12.2]: Cervical cancer screening Improvement Target: 3% over baseline improvement in women receiving cervical cancer screenings Data Source: EMR Estimated Improvement Target 1 incentive payment: $11,987	**Outcome Improvement Target 4** [IT-12.2]: Cervical cancer screening Improvement Target: 5% improvement over baseline women receiving cervical cancer screenings Data Source: EMR Estimated Improvement Target 2 Incentive payment: $26,059
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $4,834	Year 3 Estimated Outcome Amount: $11,205	Year 4 Estimated Outcome Amount: $11,987	Year 5 Estimated Outcome Amount: $26,059
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $54,085			

Title of Outcome Measure (Improvement Target): IT-12.5 – Sexually transmitted diseases
Unique RHP outcome identification number (s): 081939301.3.12/Texas Tech University Health Sciences Center 081939301
Outcome Measure Description: IT- 12.5 – Percent reduction in reported sexually transmitted diseases

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 base line rates
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement targets for each year:

- DY4:
    - IT-12.5: 3% reduction in baseline in reported STD
- DY5:
    - IT-12.5: 5% reduction in baseline in reported STD

Rationale:

Process milestones P-1, P-2, and P-5 were chosen in order to allow TTUHSC-PB to create a plan and implement it, in order to accurately gather and report data. These process milestones must be approached in DY2 – DY3.

Improvement targets were chosen so we could measure the percentage of patients with reduction in reported STDs.

Outcome Measure Valuation:

Valuation is derived by assigning weights for each project based on four criteria. Those criteria considered are:

- Meets waiver goals,
- Addresses community needs,
- Population served and
- Project Investment.

081939301.3.12	*3.IT-12.5*	*Primary Care and Prevention*	
Texas Tech University Health Sciences Center-PB			*081939301*
Related Category 1 or 2 Projects:	*081939301.2.4*		
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, needed resources, determine timelines and document implementation plans Data Source: competed strategic plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,833	**Process Milestone 2** [P-2] Establish base line rates Data Source: strategic plan Process Milestone 3 Estimated Incentive Payment: $5.603 **Process Milestone 2** [P-5] Disseminate findings, including lessons learned and best practices to stakeholders Data Source: strategic plan Process Milestone 2 Estimated Incentive Payment: $5,603	**Outcome Improvement Target 1** [IT-12.5]: Sexually transmitted diseases Improvement Target: 3% reduction in reported STDs Data Source: EMR Estimated Improvement Target 1 Incentive payment:$11,987	**Outcome Improvement Target 4** [IT-12.5]: Sexually transmitted diseases Improvement Target: 5% reduction in reported STDs screenings Data Source: EMR Estimated Improvement Target 2 Incentive payment: $26,059
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $4,833	Year 3 Estimated Outcome Amount: $11,206	Year 4 Estimated Outcome Amount: $11,987	Year 5 Estimated Outcome Amount: $26,059
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $54,085			

Identifying Information:
Outcome Measure: IT 9.2 Reduce Non Emergent ED Visits RHP Project
Unique Identifier: 127298103.3.1
Performing Provider: Permian Regional Medical Center 127298103

Outcome Measure Description:

Permian Regional Medical Center will reduce the number of non-emergent ED visits by opening a prompt care center. Andrews County is lacking access to a prompt care center forcing resident to travel outside the district or visit the emergency room after clinic hours. The target of this project is to reduce non emergent care in the ED department by 5% at the end of the project (DY5).

Rationale:

The intent of this project is to provide appropriate care in the appropriate setting therefore reduce cost and providing prompt quality care to the patients.

Outcome Measure Valuation:

IT-9.2 appropriate utilization will be to reduce all non-emergent ED visits. This project is directly related to the category 1 project 127298103.1.1. The measures for the project include the following:

Reduce non emergent visits to the hospital emergency room for any condition

DY2 will be an implementation year of obtaining a building, increasing staff and increasing clinic hours. DY2 will serve as the baseline. DY3-5 will have the goal of improving the baseline by 3% DY3, 4% DY4 and 5% DY5.

127298103.3.1	***3. IT 9.2***	***ED Appropriate Utilization***	
Permian Regional Medical Center			***127298103***
Related Category 1 or 2 Projects::	***127298103.1.1***		
Starting Point/Baseline:	***New Project***		
[redacted]			
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation planning phases and stakeholder engagement Process Milestone 1 Estimated Incentive Payment (maximum amount): $85,483	**Outcome Improvement Target 1** [IT-9.2]: 3 % improvement over baseline non emergent visits to the emergency room. Data Source: **EMR or patient chart** Outcome Improvement 1 Estimated Incentive Payment: $99,087	**Outcome Improvement Target 2** IT-9.2: 4 % improvement over baseline non emergent visits to the emergency room. Data Source: **EMR or patient chart** Outcome Improvement 2 Estimated Incentive Payment: $158,999	**Outcome Improvement Target 3** IT-9.2: 5 % improvement over baseline non emergent visits to the emergency room. Data Source: **EMR or patient chart** Outcome Improvement 3 Estimated Incentive Payment: $403,258
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $85,483	Year 3 Estimated Outcome Amount: $99,087	Year 4 Estimated Outcome Amount: $158,999	Year 5 Estimated Outcome Amount: $403,258
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $746,827			

Identifying Outcome Measure and Provider Information:

Outcome Measure: IT-9.2 ED Appropriate Utilization *(Standalone measure)*
Unique Project ID: 176354201.3.1
Performing Provider Name/TPI: Culberson Hospital / 176354201

Outcome Measure Description:

Year 2: Culberson Hospital will spend the initial year in planning for the transition of the current primary care clinic to the Patient-Centered Medical Home Model. This process will include a gap analysis and feasibility study to determine procedural steps and special needs of the program moving forward.
Year 3: Once the program initiative is underway the focus will shift to the training and education of staff on PCMH best practices. Appropriate education materials, seminars and workshops will lay a solid foundation helping staff members deliver a positive patient experience leading to increased satisfaction, care coordination, and ultimately access to care. Data baseline will be established at close of year.
Year 4: With the staff properly educated, the existing primary care clinic will undergo the transformation process to a PCMH. The PCMH framework in place will generate positive patient experiences in conjunction with demonstrably better care coordination. Strengthened primary care will within a relatively short time reduce emergency department visits. A 5% overall reduction in ED utilization is expected within this timeframe over the baseline as patients are educated and recognize the PCMH as their 'home base' for healthcare.
Year 5: Throughout the final year of implementation there will continue to be process refinement as the PCMH strives to achieve NCQA recognition. The continued patient experience and education process will continue to reduce any unnecessary reliance on the ED safety net. Another 5% reduction in ED visits is expected over this time period, resulting in a 10% net reduction over the baseline.

Rationale:

The primary goals to promote more patient-centered care focus on community wellness and enhanced coordination of care. In addition, the PCMH model is viewed as a foundation for the ability to accept the impending alternative payment models under payment reform. PCMH development is a multi-year transformational effort an innovative way to deliver care. By providing the right care at the right time and in the right setting, over time, patients in Culberson County will hopefully see their overall health improve, rely less on costly ED visits and incur fewer avoidable hospital stays.

Outcome Measure Valuation:

The creation of the PCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider.

Culberson Hospital used a basic valuation tool to measure the efficacy of potential project. The tool was centered on the following questions:

- Does the project meet the waiver goals?
- Does the project address a pressing community need?
- Which population is being served?
- What is the project investment (Resources needed)?

After receiving input from outside consultation and visiting with local stakeholders, the PCMH Project was deemed to be a top priority in strengthening the health delivery system of Culberson County. PCMH development is a multi-year transformational effort an innovative way to deliver care. By providing the right care at the right time and in the right setting, over time, patients in Culberson County will hopefully see their overall health improve, rely less on costly ED visits and incur fewer avoidable hospital stays.

176354201.3.1	***3.IT 9-2***	***ED appropriate Utilization***	
Performing Provider Name: Culberson Hospital		***TPI: 176354201***	
Related Category 1 or 2 Projects	***135235306.2.1- Enhance/Expand Medical Homes***		
Starting Point/Baseline	***Baseline will be established at conclusion of DY2***		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1 [*P-1*]: Project planning – gap analysis, identification of current capacity and feasibility Data Source: Project Planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,342	Process Milestone 2 [P-2]: Establish Baseline Rates Data Source: Registry Process Milestone 2 Estimated Incentive Payment: $16,625	Outcome Improvement Target 1 [IT-9.2]: ED appropriate Utilization *(Standalone measure)* Improvement Target: 5% reduction over DY3 baseline Data Source: Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $26,677	Outcome Improvement Target 2 [IT-9.2]: ED appropriate Utilization *(Standalone measure)* Improvement Target: 10% reduction over DY3 baseline Data Source: Registry Outcome Improvement Target 2 Estimated Incentive Payment*:* $63,792
Year 2 Estimated Outcome Amount: $14,342	Year 3 Estimated Outcome Amount: $16,625	Year 4 Estimated Outcome Amount: $26,677	Year 5 Estimated Outcome Amount: $63,792
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $121,436			

Identifying Outcome Measure and Provider Information:

Outcome measure: IT 9.2 ED Appropriate Utilization

Unique RHP outcome identification number 094204701.3.1

Performing Provider: Winkler County Memorial Hospital; TPI#094204701

Outcome Measure Description:

IT-9.2 ED appropriate utilization

We have 58% non-emergent visits in our ED (monthly averages 49-52%). This is a priority project for our organization to alleviate the high cost of non-urgent visits. In order to provide preventive and primary care, we must first have the capacity to expand access for patients to these services. In adding space to our Rural Health Clinic, we will be able to provide an alternative care setting and avoid more costly ER and inpatient care. Engaging patients in preventive and primary care will also provide care management which yields more healthy outcomes and reduces the cost burden on public payers, which represents 35% of our total payer mix.

Rationale:

Reduce all ED visits (including ACSC)

1. Reduce Emergency Department visits (CHIPRA Core Measure)
    a. Reduce Emergency Department visits for target conditions
    b. Congestive Heart Failure
    c. Diabetes
    d. End Stage Renal Disease
    e. Cardiovascular Disease /Hypertension
    f. Health/Substance Abuse
    g. Chronic Obstructive Pulmonary Disease
    h. Asthma

Outcome Measure Valuation:

a**. Numerator**: The number of individuals admitted who had a potentially preventable admission/readmission to the facility within the measurement period.

b. **Denominator:** The number of individuals seen by PCP in the rural clinic.

Project Valuation:

WCMH brings care and treatment to a level of proactive response in promoting higher standards of community health through preventative care. Without the proper continuum of care, the Winkler County population, as well as patients from Southeastern New Mexico, often arrives at the ER for treatment. The creation of the WCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider.

Winkler County Memorial Hospital used a basic valuation tool to measure the efficacy of potential project. The tool was centered on the following questions:

- Does the project meet the waiver goals?

- Does the project address a pressing community need?
- Which population is being served?
- What is the project investment (Resources needed)?

After receiving input from outside consultation and visiting with local stakeholders, the WCMH Project was deemed to be a top priority in strengthening the health delivery system of Winkler County.

094204701.3.1	***3.IT-9.2 ED appropriate utilization***	***OD- 9 Right Care, Right Setting***	
Winkler County Memorial Hospital			***094204701***
Related Category 1 or 2 Projects:	***094204701.1.1***		
Starting Point/Baseline:	***58% non-emergent visits in our ED (monthly averages 49-52%).***		
Year 2 (10/1/2012 – 9/30/2013)	**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: Encounter / claims data, ER visit records/logs Metric: TBD % decrease in non-emergent ER visits Process Milestone 1 Estimated Incentive Payment*:* $ 10,271	**Process Milestone 2 [**P- 2] Establish baseline rates Data Source: Encounter / claims data, ER visit records/logs Metric: TBD Process Milestone 2 Estimated Incentive Payment*:* $ 11,905	**Outcome Improvement Target 1 [**IT-9.2]: ED appropriate utilization- Reduce all ED visits (including ACSC); Reduce pediatric Emergency Department visits (CHIPRA Core Measure); Reduce Emergency Department visits for target conditions Data Source: Encounter / claims data, ER visit records/logs Improvement Target: TBD Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $ 19,104	**Outcome Improvement Target 2 [**IT-9.2]: ED appropriate utilization- Reduce all ED visits (including ACSC); Reduce pediatric Emergency Department visits (CHIPRA Core Measure); Reduce Emergency Department visits for target conditions Data Source: Encounter / claims data, ER visit records/logs Improvement Target: TBD Outcome Improvement 2 Estimated Incentive Payment *(maximum amount):* $ 45,683
Year 2 Estimated Outcome Amount: $ 10,271	Year 3 Estimated Outcome Amount: $ 11,905	Year 4 Estimated Outcome Amount: $ 19,104	Year 5 Estimated Outcome Amount: $ 45,683
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 86,963			

Identifying Outcome Measure and Provider Information:
Unique Identifier: 136145310.3.1
Outcome Measure: OD-2 IT-2.9 Uncontrolled Diabetes Admission Rate – PQI 14245
Performing Provider: Martin County Hospital District TPI: 136145310

Outcome Measure Description:

Process Milestones:

- **DY2:**

  P-1 – Design and Implementation – identify a care team that is tailored to the patient's health care needs. Design culturally and linguistically appropriate patient education tools. Coordinate community resources to help increase patient engagement and enrollment in diabetic self-management program. Document implementation plans.

- **DY3:**

  P-2 – Establish baseline number for the admission rates of uncontrolled diabetes patients. Evaluate and implement any revised education interventions. Continue to increase enrollment in diabetic self-management program.

Outcome Measure Description:

- **DY4:**

  Decrease the admission rate of uncontrolled diabetes patients by percentage TBD once the baseline measure is identified.

- **DY5:**

  Decrease the admission rate of uncontrolled diabetes patients by 2-3% by DY5.

Rationale:
Process milestone P-11 was determined because this is a new program for Martin County Hospital District and it will be necessary to design an effective diabetic self-management program in our community during DY2. There will need to be a proper amount of time allocated for the recruitment of a care team and design of the overall program. During DY3, the program will be fully implemented, baselines established, and conduct quality improvement evaluations for the project, including considerations for safety-net populations. Necessary adjustments and changes will be implemented at this time. Improvement targets and outcome measures were

set at TBD (once the baseline measure is identified) for DY4 and 2-3% for DY5 which Martin County Hospital believes is a reasonable target for its diabetic patient population.

Outcome Measure Valuation:

Martin County Hospital Districts takes into account the complexity, lack of available resources, and the financial burden that is required in successfully accomplishing this project. The diabetic patient population is at high risk of debilitating, life-long complications and it is extremely important that they be provided with the best possible options to effectively manage their disease. By implementing the diabetic self-management program, we are able to improve patient outcomes, promote wellness among our diabetic patient population, reduce healthcare cost, and improve overall patient satisfaction in our service area. This in turn should help to reduce our uncontrolled diabetic admission rates. We will make this investment in staffing and training initiatives to transform the system of care in Stanton. By providing the residents of Martin County with a comprehensive self-management program, clinical outcomes are improved, complications can be avoided, and healthcare cost will be reduced by decreasing the need for ER and inpatient management.

136145310.3.1	***3.IT-2.9***	***PPA: Uncontrolled Diabetes Admission Rate – PQI 14245***	
Martin County Hospital District			
Related Category 1 or 2 Projects	***136145310.2.1***		
Starting Point/Baseline	***New Project/Program***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1: [P-1]: Develop and implement a program to assist patient to better self-manage their chronic condition. Data Source: EHR, patient registry, class enrollment, and attendance records. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $36,320	**Process Milestone 2: [P-2]:** Establish baseline uncontrolled diabetes admission rates. Data Source: EHR, program registry. Process Milestone 2 Estimated Incentive Payment: $42,100	**Outcome Improvement Target 1: [IT-2.9]:** Improvement Target: Decrease the admission rate of uncontrolled diabetes patients by 2-3% by DY5. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $67,556	**Outcome Improvement Target 2: [IT-2.9]:** Improvement Target: Decrease the admission rate of uncontrolled diabetes patients by 2-3% by DY5. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $161,547
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,320	Year 3 Estimated Outcome Amount: $42,100	Year 4 Estimated Outcome Amount: $67,556	Year 5 Estimated Outcome Amount: $161,547
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $307,523			

Identifying Outcome Measure and Provider Information:

RHP project identification number: 094172602.3.1.

Outcome Measure: IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

Performing Provider: McCamey County Hospital District TPI: 094172602.

Outcome Measure Description:

P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Metric:

a. Develop plan to coordinate with Project 2 staffing plan that will engage providers and inform them of the implementation of the care transition plan

b. Date Source: Diabetes care transition plan

P- 2 Establish baseline rates

Metric:

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

b. Denominator: Members 18 to 75 years of age as of December 31 of measurement year with diabetes (type 1 and type 2)

c. Data Source: EHR and Administrative clinical data

P- 3 Develop and test data systems

Metric:

a. Patients in clinic or inpatient stay with newly diagnosed or uncontrolled diabetes.

b. Data Source: Report from Health Information System.

IT-1 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059

Metric:

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had A1C (HbA1c) control > 9.0%.

b. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).

c. Data Source: EHR, Registry, Claims, Administrative clinical data

IT-2 Measure: Improve 5% of patients HgbA1C by 1% by end of year 4.

Metric: Percent patients with improved HgbA1C.

a. Numerator: Number of patients for which HgbA1c is improved.

b. Denominator: Number of patients discharged with uncontrolled or newly diagnosed diabetes

c. Data Source: Report from Health Information System

IT-3 Measure: Improve additional 5% of patients HgbA1C by 1% by end of waiver.
Metric: Percent patients with improved HgbA1C.

a. Numerator: Number of patients for which HgbA1c is improved.

b. Denominator: Number of patients discharged with uncontrolled or newly diagnosed diabetes

c. Data Source: Report from Health Information System

Rationale:

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Our plan is addressing community need number 9, Diabetes Screening and Education. We plan to develop protocols for effectively communicating with patients and families the availability of resources for those that are newly diagnosed with diabetes or those with uncontrolled diabetes. We will establish monthly classes with a dietician, at no cost to the patient. We will also offer diabetes specific exercise classes, also at no charge. Patients will receive orders from the physician in order to attend these classes. We will establish a process for hospital-based managers to follow up with identified patients hospitalized related to diabetes 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. Clinic patients will be identified during their visit to the clinic.

Outcome Measure Valuation:

The Hospital District will have to contract with a dietician for monthly meetings. This cost will include not only meeting hours but travel time and costs. These costs are not yet determined, as it will need to be negotiated when a dietician is found. A trainer will be required

to hold the classes at the Wellness Center. The cost of the trainer's time and use of the classroom is estimated to be $2,000 per year. Other education material will also be purchased; this is estimated to be around $1,000 per year. The American Diabetes Association estimates costs at $174,000,000,000 for the 25.8 million people in the U.S. with diabetes. This cost averages at $6,745 per person with diabetes. Our current reports show the Hospital District has 66 patients with newly diagnosed or uncontrolled diabetes. Using the national average this calculates to $445,170 of cost avoidance. Also, if we are able to improve the patients quality of life that will be a tremendous benefit in a community with such a small population.

094172602.3.1	*3 IT 1.10*	*Primary Care and Chronic Disease Management* *Diabetes care HbA1c poor control*	
McCamey County Hospital District 094172602			
Related Category 1 or 2 Projects	*094172602.2.1*		
Starting Point/Baseline	*New Project*		
Year 2 **(10/1/2012-9/30/2013)**	**Year 3** **(10/1/13-9/30/14)**	**Year 4** **(10/1/14-9/30/15)**	**Year 5** **(10/1/15-9/30/16)**
Process Milestone 1 [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Diabetes care transition plan **Process Milestone 1 Estimated Incentive Payment *:*** $3,119 **Process Milestone 2 [P-2]** : Establish baseline rates **Data Source:** EHR and Administrative clinical data **Process Milestone 2Estimated Incentive Payment:** $3,119	**Process Milestone 3 [P-3]:** Develop and test data systems **Data Source:** Report from Health Information System **Process Milestone 3 Estimated Incentive Payment:** $3,411 **Outcome Improvement Target 1** [IT-1.10]: **Improvement Target:** Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 **Data Source:** EHR, Administrative clinical data **Outcome Improvement Target 1 Estimated Incentive Payment***:* $3,411	**Outcome Improvement Target 2** [IT-1.10]: **Improvement Target:** Improve 5 % patients participating in the program HgbA1C by 1% **Data Source:** Report from Health Information System **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $7,136	**Outcome Improvement Target 3** [IT-1.10]: **Improvement Target:** Improve 10 % of patients participating in the program HgbA1C by 1% **Data Source:** Report from Health Information System **Outcome Improvement Target 3 Estimated Incentive Payment*:*** $8,887
Year 2 Estimated Outcome Amount: $6,238	Year 3 Estimated Outcome Amount: $6,822	Year 4 Estimated Outcome Amount: $7,136	Year 5 Estimated Outcome Amount: $8,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $29,083			

Identifying Information
Unique Category 3 Identifier: 112711003.3.1
Identifying Outcome Measure: IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:
Process Milestone 1-2: DY2-DY3 will be used to analyze the current EHR within the hospital and identify improvement in data collection to ensure an accurate baseline. If the current EHR does not have the capabilities to maintain this data, a tool will be developed in order to track scores. Once the EHR/survey tool has been modified for clinic purposes, ORMC will be able to obtain a baseline on satisfaction scores.

Improvement Milestone 1-2: The improvement target is TBD after the baseline is captured in the previous demonstration year. With the collection and development of information for creation of a patient registry, ORMC will be better suited to develop an improvement target for DY4- DY5.

Rationale:
ORMC will develop a tool based on the CAHPS domain of "Getting Timely Appointments, Care, and Information," and increase their scores in DY4 and 5. According to Agency for Healthcare Research and Quality, CAHPS "covers topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess." This project will display an increase in access through increased primary care encounters along with ensuring that patients are receiving this care in a timely manner. ORMC feels it is imperative that developing processes and maintaining efficient workflow will increase its capabilities to increase encounters, but must be vigilant to consumers in regards to the timeliness of care and information dispersed.

Outcome Measure Valuation:
The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This outcome is valued as is due to the community need regarding access to primary care and the infrastructure development in order to complete this. Development and technical support in order to track this data was also taken into consideration as this will be a new metric for ORMC to develop and maintain. Significant support will need to be maintained once functionality has been established along with maintenance of the processes and systems developed.

112711003.3.1	**3.IT-6.1**	[OD-6] Percent Improvement Over Baseline of Patient Satisfaction Scores	
Odessa Regional Medical Center			112711003
Related Category 1 or 2 Projects:	*112711003.1.1*		
Starting Point/Baseline:	*New Project*		
Year 2 (10/1/2012 – 9/30/2013)	**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] Identify current capacity within primary care clinics to capture necessary data for improvement target. **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment: $145,985	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $83,941 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 2 Estimated Incentive Payment: $83,942	**Outcome Improvement Target 1**[IT-6.1] Increase patient satisfaction scores regarding timeliness of care, appointments, and information. determined in year 3 **Improvement Target**: TBD% Increase in Patient Satisfaction Scores **Data Source:** EHR Improvement Target 1 Estimated Incentive Payment: $266,934	**Outcome Improvement Target 2**[IT-6.1] Increase patient satisfaction scores regarding timeliness of care, appointments, and information. determined in year 3 **Improvement Target**: TBD% Increase in Patient satisfaction Scores **Data Source:** EHR Improvement Target 2 Estimated Incentive Payment: $634,236
Year 2 Estimated Outcome Amount: $145,985	Year 3 Estimated Outcome Amount: $167,883	Year 4 Estimated Outcome Amount: $266,934	Year 5 Estimated Outcome Amount: $634,236
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,215,038			

Identifying Information
Unique Category 3 Identifier: 112711003.3.2
Identifying Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measure (Abdominal Aortic Aneurysm)
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:
Process Milestone 1-3: DY1 will be used to develop infrastructure necessary to implement hospital EHR system into the mobile unit. Significant Information Technology support is expected in order to modify system for mobile clinic implementation. In DY3 full implementation of the mobile unit will be launched, allowing for a baseline to be captured.

Improvement Target 1-2: The improvement targets will be tracked and monitored after the baseline is collected. The improvement target will be determined once capabilities have been realized and established. ORMC will increase the number of screenings for the selected preventive measures through its EHR system in DY4 and DY5.

Rationale:
The screenings chosen include: Carotid Artery Stenosis, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm screenings, due to cardiac conditions being the number one leading cause of death within RHP 14. Each of the included screenings was chosen off the listing provided by the U.S. Preventive Services Task Force, a department of the Agency for Healthcare Research and Quality. The Guide to Clinical Preventive Services provides recommendations for populations at risk, which closely correlates with the population within RHP 14. Through the established mobile clinic and improvement in aforementioned screenings, ORMC will be able to assist in reducing complications and increase primary care services throughout the RHP.

Screenings for Abdominal Aortic Aneurysm by ultrasonography has been recommended for men between the ages of 65-75 and who have ever smoked by the U.S. Preventive Services Task Force. The USPSTF has given this screening a grade of "B" within the recommended population in which Region 14 experiences a high prevalence of smoking adults, whom would benefit from this screening being performed.

Outcome Measure Valuation:
In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.

The value of accomplishing the improvement target for this outcome domain is manifold: it will improve patient health outcomes, patient quality of life, patient functionality, and will reduce the short term and long terms costs of treating patients for preventable and/or manageable condition.

112711003.3.2	*3.IT-12.5*	*[IT-12.5] Other USPSTF-endorsed screening outcome measure)*	
Odessa Regional Medical Center			**112711003**
Related Category 1 or 2 Projects:	**112711003.1.2**		
Starting Point/Baseline:	**New Project**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3] Develop capabilities to install into mobile unit for implementation in DY3 **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $43,795	**Process Milestone 2** [P-3]: Develop and test data system to ensure accurate data and clinical information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $25,183 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $25,182	**Outcome Improvement Target 1** [IT12.5] Increase the number of screenings for population in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $80,080	**Outcome Improvement Target 2** [IT-12.5]: Increase the number of screenings for populations in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 3 Estimated Incentive Payment: $190,270
Year 2 Estimated Outcome Amount: $43,795	**Year 3 Estimated Outcome Amount: $50,365**	**Year 4 Estimated Outcome Amount: $80,080**	**Year 5 Estimated Outcome Amount: $190,270**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $364,510			

Identifying Information
Unique Category 3 Identifier: 112711003.3.3
Identifying Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measure (High Blood Pressure Screenings)
Performing Provider: Odessa Regional Medical Center [TPI: 112711003]

Outcome Measure Description:
Process Milestone 1-3: DY1 will be used to develop infrastructure necessary to implement hospital EHR system into the mobile unit. Significant Information Technology support is expected in order to modify system for mobile clinic implementation. In DY3 full implementation of the mobile unit will be launched, allowing for a baseline to be captured.

Improvement Target 1-2: The improvement targets will be tracked and monitored after the baseline is collected. The improvement target will be determined once capabilities have been realized and established. ORMC will increase the number of screenings for the selected preventive measures through its EHR system in DY4 and DY5.

Rationale:
The screenings chosen include screening for high blood pressure, Aortic Aneurysm screenings, and Peripheral Arterial Diseases, due to cardiac conditions being the number one leading cause of death within RHP 14. Each of the included screenings was chosen off the listing provided by the U.S. Preventive Services Task Force, a department of the Agency for Healthcare Research and Quality. The Guide to Clinical Preventive Services provides recommendations for populations at risk, which closely correlates with the population within RHP 14. Through the established mobile clinic and improvement in aforementioned screenings, ORMC will be able to assist in reducing complications and increase primary care services throughout the RHP. Screening for high blood pressure was given a grade of "A" for adults aged 18 and older by the U.S. Preventive Services Task Force. Due to the prevalence of this disease within the region, the community need for this service to be taken through a mobile program is high.

Outcome Measure Valuation:
In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.
The value of accomplishing the improvement target for this outcome domain is manifold: it will improve patient health outcomes, patient quality of life, patient functionality, and will reduce the short term and long terms costs of treating patients for preventable and/or manageable conditions.

112711003.3.3	*3.IT-12.5*	*[IT-12.5] Other USPSTF-endorsed screening outcome measure)-High Blood Pressure Screenings*	
Odessa Regional Medical Center			*112711003*
Related Category 1 or 2 Projects:	*112711003.1.2*		
Starting Point/Baseline:	*New Project*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3] Develop capabilities to install into mobile unit for implementation in DY3 **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $43,795	**Process Milestone 2** [P-3]: Develop and test data system to ensure accurate data and clinical information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $25,183 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $25,182	**Outcome Improvement Target 1** [IT12.5] Increase the number of screenings for population in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $80,080	**Outcome Improvement Target 2** [IT-12.5]: Increase the number of screenings for populations in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $190,270
Year 2 Estimated Outcome Amount: $43,795	**Year 3 Estimated Outcome Amount: $50,365**	**Year 4 Estimated Outcome Amount: $80,080**	**Year 5 Estimated Outcome Amount: $190,270**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $364,510			

Identifying Information
Unique Category 3 Identifier: 112711003.3.4
Identifying Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measure (Peripheral Arterial Disease)
Performing Provider: Odessa Regional Medical Center [TPI: 112711003]

Outcome Measure Description:
Process Milestone 1-3: DY1 will be used to develop infrastructure necessary to implement hospital EHR system into the mobile unit. Significant Information Technology support is expected in order to modify system for mobile clinic implementation. In DY3 full implementation of the mobile unit will be launched, allowing for a baseline to be captured.

Improvement Target 1-2: The improvement targets will be tracked and monitored after the baseline is collected. The improvement target will be determined once capabilities have been realized and established. ORMC will increase the number of screenings for the selected preventive measures through its EHR system in DY4 and DY5.

Rationale:
The screenings chosen include: Carotid Artery Stenosis, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm screenings, due to cardiac conditions being the number one leading cause of death within RHP 14. Each of the included screenings was chosen off the listing provided by the U.S. Preventive Services Task Force, a department of the Agency for Healthcare Research and Quality. The Guide to Clinical Preventive Services provides recommendations for populations at risk, which closely correlates with the population within RHP 14. Through the established mobile clinic and improvement in aforementioned screenings, ORMC will be able to assist in reducing complications and increase primary care services throughout the RHP.
Screening for PAD through Ankle Brachial Index is recommended on an annual level the American Heart Association and on an annual level for those diagnosed with Diabetes by the American Diabetes Association.

Outcome Measure Valuation:
In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.
The value of accomplishing the improvement target for this outcome domain is manifold: it will improve patient health outcomes, patient quality of life, patient functionality, and will reduce the short term and long terms costs of treating patients for preventable and/or manageable conditions.

112711003.3.4	*3.IT-12.5*	*[IT-12.5] Other USPSTF-endorsed screening outcome measure)*	
Odessa Regional Medical Center			***112711003***
Related Category 1 or 2 Projects:	***112711003.1.2***		
Starting Point/Baseline:	***New Project***		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3] Develop capabilities to install into mobile unit for implementation in DY3 **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $43,795	**Process Milestone 2** [P-3]: Develop and test data system to ensure accurate data and clinical information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $25,183 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $25,182	**Outcome Improvement Target 1** [IT12.5] Increase the number of screenings for population in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $80,080	**Outcome Improvement Target 2** [IT-12.5]: Increase the number of screenings for populations in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $190,270
Year 2 Estimated Outcome Amount: $43,796	**Year 3 Estimated Outcome Amount: $50,365**	**Year 4 Estimated Outcome Amount:$80,081**	**Year 5 Estimated Outcome Amount: $190,272**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $364,514			

Identifying Information
Unique Category 3 Identifier: 112711003.3.5
Identifying Outcome Measure: IT-3.7 Potentially Preventable Re-Admissions: Stroke/CVA 30 day Readmission Rates
Performing Provider: Odessa Regional Medical Center [TPI: 112711003]

Outcome Measure Description:
Process Milestone 1-2: DY2-DY3 will be used to analyze the current EHR within the hospital and identify improvement in data collection to ensure an accurate baseline, and registry can be captured. Capabilities will need to be identified in order to develop an interface with the selected vendor for seamless integration of both systems.
Improvement Milestone 1-2: The improvement target is TBD after the baseline is captured in the previous demonstration year. With the collection and development of information for creation of a patient registry, ORMC will be better suited to develop an improvement target for DY4- DY5.

Rationale:
Odessa Regional Medical Center will develop a telemedicine program based upon a needs assessment that will be conducted in DY2. The category 3 measure will be confirmed once the needs assessment is completed and the selected telemedicine program has been confirmed. Odessa Regional Medical Center has had feedback from several members within the RHP that a Neuro-telemedicine program would be beneficial due to lack of capabilities and necessity of timely intervention. If developed properly, stroke readmissions would be greatly reduced due to the proper identification and treatment of a stroke. This condition causes severe health consequences, and is often fatal, so it is an imperative reform when considered in light of patient health outcomes and quality/quantity of life. In 2009, RHP 14 had 169 deaths due to Cerebrovascular Disease (CVA) and that number has only expected to increase. Potentially preventable hospitalizations for hypertension led to over $10 million in charges for this condition between 2005 and 2010. The Neuro-Telemedicine program will also lead to a better ability to differentiate between a Hemorrhagic and Ischemic Stroke, resulting in quicker treatment. While ORMC has the capability to treat an ischemic stroke, through administration of TPA, our capability to treat hemorrhagic strokes remains limited. Telemedicine would allow timely identification of stroke type and referral to the correct level of care.
***If another telemedicine program is determined to be more beneficial within the RHP, Odessa Regional Medical Center will re-evaluate its category 3 measure dependent on the community need.**

Outcome Measure Valuation:
The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community (especially in the hospital ICU) by addressing readmission for Stroke (CVA). The development and implementation of the program will take significant resources, due to developing the infrastructure and an interface between the hospital EHR and vendor applications. This

expense is justified due to an increase the timeliness of care that will be delivered, especially considering the stroke treatment timeframe.

112711003.3.5	***3.IT-3.7***	***Stroke/CVA 30 Day Readmission Rates***	
Odessa Regional Medical Center 112711003			
Related Category 1 or 2 Projects	***112711003.1.3***		
Starting Point/Baseline	***Odessa Regional Medical Center***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1] Identify current capabilities regarding tele-medicine program with identified vendor **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment: $72,993	**Process Milestone 2** [P-3]: Develop and test data systems to ensure compatibility with EHR and telemedicine information systems. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $41,971 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $41,971	**Outcome Improvement Target 1**[IT-3.7] Decrease Stroke/CVA 30 Day readmission rate by certain target to be determined in year 3 **Improvement Target**: TBD% Decrease **Data Source:** EHR Improvement Milestone 1 Estimated Incentive Payment: $133,467	**Outcome Improvement Target 2**: [IT-3.7] Decrease Stroke/CVA 30 Day Readmission rate by certain target to be determined in year 3 **Improvement Target**: TBD% decrease **Data Source:** EHR Improvement Milestone 2 Estimated Incentive Payment: $317,118
Year 2 Estimated Outcome Amount: $72,993	Year 3 Estimated Outcome Amount: $83,942	Year 4 Estimated Outcome Amount: $133,467	Year 5 Estimated Outcome Amount: $317,118
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $607,520			

Identifying Information
Unique Category 3 Identifier: 112711003.3.6
Identifying Outcome Measure: IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0)
Performing Provider: Odessa Regional Medical Center 112711003

Outcome Measure Description:
Process Milestone 1: Year one will be used for planning the diabetes program at Odessa Regional Medical Center. An action plan will be developed that is used to guide the program through its implementation.

Process Milestone 2-3: Year two will be used to develop a baseline target for our improvement measures and report this to the Board of Directors.

Improvement Milestone: The improvement target for DY4 and DY5 milestone will be dependent on the baseline year. Once the baseline is established, the improvement target will be discussed and reviewed for approval from our Board of Directors.

Rationale:
The American Diabetes Association estimates that up to 18% of all pregnancies are affected by gestational diabetes which can lead to large babies, neonatal hypoglycemia, and preeclampsia. ORMC will look to monitor HbA1c levels to decrease these risks associated with mothers and babies. According to the Texas Department of Human Services, in 2007, 50.3% of the premature births were from Hispanic mothers. Women of Hispanic origin have a 5-8% chance of developing gestational diabetes compared to a 1.5-2% risk in non-Hispanic white women. Approximately 53% of the population in Ector County is of Hispanic origin. With proper diet, medication and monitoring complications from gestational diabetes can be controlled.

Outcome Measure Valuation:
In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.

The value of accomplishing the improvement target for this outcome domain is manifold: it will improve patient (both mother and infant) health outcomes, quality of life, functionality, and will reduce the short term and long terms costs of treating the consequences of gestational diabetes.

112711003.3.6	*3.IT-1.10*	*IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%).*	
Odessa Regional Medical Center			*112711003*
Related Category 1 or 2 Projects	*112711003.1.4*		
Starting Point/Baseline	*New Project*		
Year 2 (10/1/2012 – 9/30/2013)	**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] Plan development of comprehensive diabetes program, including necessary resources and time frames. Data Source**:** Action Plan Process Milestone 1 Incentive Payment:$116,788	**Process Milestone 2**[P-2] Establish baseline rates for chosen improvement target IT-1.10. **Data Source:** Baseline from Registry Milestone Incentive Payment: $44,769 **Process Milestone 3 [P-5]** Disseminate baseline rates established in DY 1 and report on improvement target rates for DY 4 to ORMC Board Meeting Data Source: Meeting Minutes Milestone 2 Incentive Payment: $44,769 **Outcome Improvement Target 1:** [IT-1.10]: Diabetes care: HbA1c control (>9.0%) **Improvement Target:** TBD **Data Source:** Registry Outcome Improvement Target 1 Milestone Incentive Payment: $44,769	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c control (>9.0%) Improvement Target: TBD Data Source**:** Registry Improvement Milestone 1 Incentive Payment: $213,547	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c control (>9.0%) Improvement Target: TBD Data Source**:** Registry Improvement Milestone 2 Incentive Payment: $507,389

Year 2 Estimated Outcome Amount: $116,788	Year 3 Estimated Outcome Amount: $134,307	Year 4 Estimated Outcome Amount: $213,547	Year 5 Estimated Outcome Amount: $507,389
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $972,031			

Identifying Information
Unique category 3 Identifier: 112711003.3.7
Identifying Outcome Measure: IT-12.5 Other USPSTF Endorsed Screening Outcome Measure *(non-standalone)* - Breast Cancer Screening
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:
Process Milestone 1-3: DY 2-3 will be used to develop and test current infrastructure within our clinic. Once current capabilities have been identified, ORMC will test the system, to ensure accurate data is being captured. The amount of screenings in each of the preventive measures chosen will be documented and established in DY3 in order to develop improvement targets for DY4 and 5.

Improvement Target 1-2: Once the baseline is established, ORMC will use DY 4-5 as the years it will document improvement in the screenings chosen within the "Guide to Clinical Preventive Services" developed by the Agency for Healthcare Research and Quality.

Rationale:
The screenings chosen include: Breast Cancer screening, Osteoporosis screening, and dietary counseling, which were included due to the impact it has within the targeted population. Each of the included screenings was chosen off the listing provided by the U.S. Preventive Services Task Force, a department of the Agency for Healthcare Research and Quality. ORMC will develop capabilities to ensure accurate screenings for the previously mentioned. Digital mammography will be installed within the clinic for breast cancer screening, along with a bone density machine. Dietary screenings will be performed due to RHP 14 having a higher incidence in Angina, Diabetes, and Hypertension, according to Texas Department of State Health Services.
Annual Breast Cancer Screening was given a grade of "B" and recommended by the U.S. Preventive Services Task Force. Annual breast cancer screening was also used by the Department of Health and Human Services in implementation of the Affordable Care Act.

Outcome Measure Valuation:
In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community. Valuation also took into consideration the infrastructure necessary to implement the program, such as digital mammography, bone density machine, implementation of EHR, and operational costs. It also took into the account the potential for healthcare savings for patients with early diagnosis and treatments.

112711003.3.7	***3.IT-12.5***	***Other USPSTF-endorsed screening outcome measure***	
Odessa Regional Medical Center			***112711003***
Related Category 1 or 2 Projects:	***112711003.1.5***		
Starting Point/Baseline:	***New Project***		
Year 2 (10/1/2012 – 9/30/2013)	**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] Identify current capacity within EHR to capture necessary data for improvement target **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $38,929	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $22,385 **Process Milestone 4:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $22,384	**Outcome Improvement Target 1** [IT12.5] Increase the number of screenings for population in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $71,182	**Outcome Improvement Target 2** [IT-12.5]: Increase the number of screenings for populations in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $169,129
Year 2 Estimated Outcome Amount: $38,929	Year 3 Estimated Outcome Amount: $44,769	Year 4 Estimated Outcome Amount: $71,182	Year 5 Estimated Outcome Amount: $169,129
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$324,009			

Identifying Information
Unique Category 3 Identifier: 112711003.3.8
Identifying Outcome Measure: IT-12.5 Other USPSTF Endorsed Screening Outcome Measure *(non-standalone)* Osteoporosis Screening
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:

Process Milestone 1-3: DY 2-3 will be used to develop and test current infrastructure within our clinic. Once current capabilities have been identified, ORMC will test the system, to ensure accurate data is being captured. The amount of screenings in each of the preventive measures chosen will be documented and established in DY3 in order to develop improvement targets for DY4 and 5.
Improvement Target 1-2: Once the baseline is established, ORMC will use DY 4-5 as the years it will document improvement in the screenings chosen within the "Guide to Clinical Preventive Services" developed by the Agency for Healthcare Research and Quality.

Rationale:

The screenings chosen include: Breast Cancer screening, Osteoporosis screening, and dietary counseling, which were included due to the impact it has within the targeted population. Each of the included screenings was chosen off the listing provided by the U.S. Preventive Services Task Force, a department of the Agency for Healthcare Research and Quality. ORMC will develop capabilities to ensure accurate screenings for the previously mentioned. Digital mammography will be installed within the clinic for breast cancer screening, along with a bone density machine. Dietary screenings will be performed due to RHP 14 having a higher incidence in Angina, Diabetes, and Hypertension, according to Texas Department of State Health Services.
Osteoporosis Screening was given a grade of "B" and recommended by the U.S. Preventive Services Task Force for woman age 65 and older. The USPSTF also recommends testing for woman at age 60 if they are at an increased risk of fractures.

Outcome Measure Valuation:

In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community. Valuation also took into consideration the infrastructure necessary to implement the program, such as digital mammography, bone density machine, implementation of EHR, and operational costs. It also took into the account the potential for healthcare savings for patients with early diagnosis and treatments.

112711003.3.8	***3.IT-12.5***	***Other USPSTF-endorsed screening outcome measure***	
Odessa Regional Medical Center			***112711003***
Related Category 1 or 2 Projects:	***112711003.1.5***		
Starting Point/Baseline:	***New Project***		
Year 2 **(10/1/2012 – 9/30/2013)**	**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] Identify current capacity within EHR to capture necessary data for improvement target **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $38,929	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $22,385 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $22,384	**Outcome Improvement Target 1** [IT12.5] Increase the number of screenings for population in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $71,182	**Outcome Improvement Target 2** [IT-12.5]: Increase the number of screenings for populations in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $169,129
Year 2 Estimated Outcome Amount: $38,929	Year 3 Estimated Outcome Amount: $44,769	Year 4 Estimated Outcome Amount: $71,182	Year 5 Estimated Outcome Amount: $169,129
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):*$324,009			

Identifying Information
Unique Category 3 Identifier: 112711003.3.9
Identifying Outcome Measure: IT-12.5 Other USPSTF Endorsed Screening Outcome Measure *(non-standalone)*: Behavioral Counseling to Promote Healthy Diet
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:

Process Milestone 1-3: DY 2-3 will be used to develop and test current infrastructure within our clinic. Once current capabilities have been identified, ORMC will test the system, to ensure accurate data is being captured. The amount of screenings in each of the preventive measures chosen will be documented and established in DY3 in order to develop improvement targets for DY4 and 5.
Improvement Target 1-2: Once the baseline is established, ORMC will use DY 4-5 as the years it will document improvement in the screenings chosen within the "Guide to Clinical Preventive Services" developed by the Agency for Healthcare Research and Quality.

Rationale:

The screenings chosen include: Breast Cancer screening, Osteoporosis screening, and dietary counseling, which were included due to the impact it has within the targeted population. Each of the included screenings was chosen off the listing provided by the U.S. Preventive Services Task Force, a department of the Agency for Healthcare Research and Quality. ORMC will develop capabilities to ensure accurate screenings for the previously mentioned. Digital mammography will be installed within the clinic for breast cancer screening, along with a bone density machine. Dietary screenings will be performed due to RHP 14 having a higher incidence in Angina, Diabetes, and Hypertension, according to Texas Department of State Health Services.
The USPSTF found good evidence that medium- to high-intensity counseling interventions can produce medium-to-large changes in average daily intake of core components of a healthy diet (including saturated fat, fiber, fruit, and vegetables) among adult patients at increased risk for diet-related chronic disease and gave this recommendation a "B".

Outcome Measure Valuation:

In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community. Valuation also took into consideration the infrastructure necessary to implement the program, such as digital mammography, bone density machine, implementation of EHR, and operational costs. It also took into the account the potential for healthcare savings for patients with early diagnosis and treatments.

112711003.3.9	***3.IT-12.5***	***Other USPSTF-endorsed screening outcome measure***	
Odessa Regional Medical Center			***112711003***
Related Category 1 or 2 Projects:	***112711003.1.5***		
Starting Point/Baseline:	***New Project***		
Year 2 **(10/1/2012 – 9/30/2013)**	**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] Identify current capacity within EHR to capture necessary data for improvement target **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $38,930	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $22,384 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $22,385	**Outcome Improvement Target 1** [IT12.5] Increase the number of screenings for population in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $71,182	**Outcome Improvement Target 2** [IT-12.5]: Increase the number of screenings for populations in which clinic serves. **Improvement Target**: TBD% Increase **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $169,130
Year 2 Estimated Outcome Amount: $38,930	Year 3 Estimated Outcome Amount: $44,769	Year 4 Estimated Outcome Amount: $71,183	Year 5 Estimated Outcome Amount: $169,130
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*:$324,012			

Identifying Information
Unique Category 3 Identifier: 112711003.3.10
Identifying Outcome Measure: IT-4.8 Sepsis Mortality *(Standalone measur*e**)**
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:

Process Milestone 1-2: DY2-DY3 will be used to analyze the current EHR within the hospital and identify improvement in data collection to ensure an accurate baseline, and bundle compliance can be captured. Once the EHR has been modified for collection purposes, ORMC will be able to obtain a baseline Sepsis Mortality rate and monitor compliance with both Sepsis bundles.
Improvement Milestone 1-2: The improvement target is TBD after the baseline is captured in the previous demonstration year. Once data can be accurately captured, compliance with the Sepsis bundles and mortality rates can be tracked and documented, giving ORMC and accurate baseline for DY4 and DY5.

Rationale:

The Institute of Healthcare Improvement and Surviving Sepsis Campaign established evidence-based guidelines in 2008, and has since supported the use of the Sepsis Resuscitation and Management bundles. The IHI website recognizes the Sepsis bundles as an organized and evidence based process that when implemented in a complete and timely manner can improve outcomes. ORMC will implement both bundles and track its compliance in order to reduce sepsis mortality rates.

Outcome Measure Valuation:

In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community. The value of accomplishing the improvement target for this outcome domain is twofold: it will improve patient health outcomes and will reduce the high costs of treating patients in the ICU with fatal outcomes. Instead, patients will be treated quickly and effectively, thereby reducing the mortality rate, reducing the cost of treatment, and improving patient longevity, functionality, and quality of life.

112711003.3.10	***3.IT-4.8***	***Sepsis Mortality***	
Odessa Regional Medical Center			***112711003***
Related Category 1 or 2 Projects:	***112711003.2.1***		
Starting Point/Baseline:	***New project***		
Year 2 **(10/1/2012 – 9/30/2013)**	**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] Identify current capacity within EHR to capture necessary data for improvement target such as compliance with Sepsis Bundles **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $116,789	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $67,153 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $67,154	**Outcome Improvement Target 1**[IT-4.8] Decrease Sepsis mortality rate compared to baseline year. **Improvement Target**: TBD% decrease in Sepsis Mortality Rate **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $213,549	**Outcome Improvement Target 2** [IT-4.8]: Decrease Sepsis mortality rate compared to baseline year. **Improvement Target**: TBD% decrease in Sepsis Mortality Rate **Data Source:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $507,389
Year 2 Estimated Outcome Amount: $116,789	Year 3 Estimated Outcome Amount: $134,307	Year 4 Estimated Outcome Amount: $213,549	Year 5 Estimated Outcome Amount: $507,389
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$972,034			

Identifying Information
Unique Category 3 Identifier: 112711003.3.11
Identifying Outcome Measure: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) (Standalone measure)
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:
Process Milestone 1: Year one will be used for planning the diabetes program at Odessa Regional Medical Center. An action plan will be developed that is used to guide the program through its implementation.

Process Milestone 2-3: Year two will be used to develop a baseline target for our improvement measures and report this to the Board of Directors.

Improvement Milestone: The improvement target for DY4 and DY5 milestone will be dependent on the baseline year. Once the baseline is established, the improvement target will be discussed and reviewed for approval from our Board of Directors.

Rationale:
IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%). Management of one's glucose levels is key to managing diabetes and leading to better health outcomes. In 2009, the American Diabetes Association issued a statement related to glucose management, "Lowering A1C to below or around 7% has been shown to reduce micro vascular and neuropathic complications of type 1 and type 2 diabetes." With monitoring this improvement measure, Odessa Regional Medical Center will be able to better manage diabetic patients by identifying diabetes through the inpatient center, then through compliance with diabetes management through its outpatient program.

Outcome Measure Valuation:
In determining the value of this project, ORMC analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.
The value of accomplishing the improvement target for this outcome domain is manifold: it will improve patient health outcomes, patient quality of life, patient functionality, and will reduce the short term and long terms costs of treating the consequences of uncontrolled diabetes.

112711003.3.11	***3.IT-1.10***	***Diabetes Care: HbA1c Poor Control (>9.0%)***	
Odessa Regional Medical Center - 112711003			
Related Category 1 or 2 Projects	***112711003.2.2***		
Starting Point/Baseline	***N/A***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: *[P-1] Plan* development of comprehensive diabetes program, including necessary resources and time frames. ***Data Source:*** Action Plan Process Milestone 1 Incentive Payment: $94,891	**Process Milestone 2**[*P-2]* Establish baseline rates for chosen improvement target. ***Data Source:*** Baseline from Registry Milestone Incentive Payment: $36,374 **Process Milestone 3 [P-5]** Disseminate baseline rates established in DY 1 and report on improvement target rates for DY 4 to ORMC Board Meeting ***Data Source***: Meeting Minutes Process Milestone 2 Incentive Payment: $36,374 **Outcome Improvement Target 1:** [IT-1.10]: Diabetes care: HbA1c control (>9.0%) ***Improvement Target:*** TBD ***Data Source:*** Registry Outcome Improvement Milestone 1 Incentive Payment: $36,375	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c control (>9.0%) Improvement Target: TBD% Increase in patients meeting goals ***Data Source:*** Registry Outcome Milestone 2 Incentive Payment: $173,507	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c control (>9.0%) Improvement Target: TBD% Increase in patients meeting goals ***Data Source:*** Registry Outcome Milestone 3 Incentive Payment: $412,254

Year 2 Estimated Outcome Amount: $94,891	Year 3 Estimated Outcome Amount: $109,123	Year 4 Estimated Outcome Amount: $173,507	Year 5 Estimated Outcome Amount: $412,254
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $789,775			

Identifying Information
Unique Category 3 Identifier: 112711003.3.12
Identifying Outcome Measure: IT-3.2 Potentially Preventable Re-Admissions: CHF 30 day Readmission Rates
Performing Provider: Odessa Regional Medical Center [TPI: 112711003]

Outcome Measure Description:
Process Milestone 1-2: DY2-DY3 will be used to analyze the current EHR within the hospital and identify improvement in data collection to ensure an accurate baseline, and registry can be captured. Once the EHR has been modified for clinic purposes, ORMC will be able to obtain a baseline readmission rate and develop a registry for CHF patients

Improvement Milestone 1-2: The improvement target is TBD after the baseline is captured in the previous demonstration year. With the collection and development of information for creation of a patient registry, ORMC will be better suited to develop an improvement target for DY4- DY5.

Rationale:
The goal is for all CHF patients presenting to ORMC be treated through the CHF clinic. Through the development of a patient registry, ORMC will be able to ensure treatment protocols are followed and issues after the hospital visit are addressed in a timely, less costly environment. The Institute for Healthcare Improvement has developed a Mentor Hospital Registry documenting several hospitals that have implemented a program similar to that ORMC will employ. Through the implementation of these processes, these hospitals have significantly reduced CHF readmissions and help manage this condition in a more cost effective manner. This condition causes severe health consequences, and is often fatal, so it is an imperative reform when considered in light of patient health outcomes and quality/quantity of life. Between 2005 and 2010, congestive heart failure was the most frequently occurring potentially preventable hospitalization in this region. Potentially preventable hospitalizations led to over $115 million in charges for this condition between 2005 and 2010.

Outcome Measure Valuation:
The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks reduce the cost of delivering care in the community (especially in the hospital ICU) by addressing readmission for congestive heart failure. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run, making it a high value project.

112711003.3.12	*3.IT-3.2*	*[OD-3] Potentially Preventable Re-Admissions: CHF 30 day Readmission Rates*	
Odessa Regional Medical Center 112711003			
Related Category 1 or 2 Projects	***112711003.2.3***		
Starting Point/Baseline	***Developed in DY 3***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1] Identify current capacity within EHR to capture necessary data for improvement target **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment: $102,190	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $58,759 **Process Milestone 3:** [P-2] Develop baseline for improvement measure **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $58,759	**Outcome Improvement Target 1:** [IT-3.2] Decrease readmission rate by certain target to be determined in year 3 **Improvement Target**: TBD% decrease in CHF readmission rate over DY Baseline **Data Source:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $186,854	**Outcome Improvement Target 2**: [IT-3.2] Decrease readmission rate by certain target to be determined in year 3 **Improvement Target**: TBD% decrease in CHF readmission rate over DY3 Baseline **Data Source:** EHR Outcome Improvement Target 2Estimated Incentive Payment: $443,965
Year 2 Estimated Outcome Amount: $102,190	Year 3 Estimated Outcome Amount: $117,518	Year 4 Estimated Outcome Amount: $186,854	Year 5 Estimated Outcome Amount: $443,965
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $850,527			

Identifying Information
Unique Category 3 Identifier: 112711003.3.13
Identifying Outcome Measure: IT-9.2 ED Appropriate Utilization
Performing Provider: Odessa Regional Medical Center TPI: 112711003

Outcome Measure Description:
Process Milestone 1-2: DY2-DY3 will be used to analyze the current EHR within the hospital and identify improvement in data collection to ensure an accurate baseline, and registry can be captured. Once the EHR has been modified for clinic purposes, ORMC will be able to obtain baseline information to identify patient population and targeted conditions through the ED.
Improvement Milestone 1-2: The improvement target is TBD after the baseline is captured in the previous demonstration year. With the collection and development of information for creation of a patient registry, ORMC will be better suited to develop an improvement target for DY4- DY5.

Rationale:
Currently, ORMC has identified "frequent flyers" among ED patients as a target population and therefore an initial candidate to develop a navigation program. The main goal of this program will be to track an identified patient group and ensure the patient navigation program is assisting in managing their care in a cost effective environment as opposed to utilizing the emergency department. The patient navigator will help coordinate care and direct them to the care which is appropriate for their condition. This will be demonstrated by monitoring appropriate utilization of the Emergency Department in correlation to specific conditions to be determined once a baseline is established. In a case study developed by the Commonwealth Fund, Genesys Health System in Flint, Michigan implemented "health navigators" and reduced unnecessary ED visits by 14.7% compared to competitors (Klein, 2010)[30].

Outcome Measure Valuation:
The valuation of each ORMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project seeks to reduce the cost of delivering care in the community (especially in the hospital Emergency Room) by addressing appropriate use of the ED for those identified by the needs assessment. Developing a mechanism to ensure proper utilization of the Emergency Department will assist in reducing cost of care for persons not needing a visit to the ED. The development and implementation of the program will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run making it a high value project.

---

[30] Klein, Sarah. "Genesys HealthWorks: Pursuing the Triple Aim Through a Primary Care-Based Delivery System, Integrated Self-Management Support, and Community Partnerships." The Commonwealth Fund (2010): 32.

112711003.3.13	***3.IT-9.2***	***ED Appropriate Utilization***	
Odessa Regional Medical Center 112711003			
Related Category 1 or 2 Projects	***112711003.2.4***		
Starting Point/Baseline	***Odessa Regional Medical Center***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-1] Identify current capacity within EHR to capture necessary data for improvement target **Data Source:** Assessment Documentation Process Milestone 1 Estimated Incentive Payment: $102,190	**Process Milestone 2** [P-3]: Develop and test data systems to ensure accurate data and registry information is tracked. **Data Source:** EHR Report Process Milestone 2 Estimated Incentive Payment: $58,759 **Process Milestone 3:** [P-2] Develop baseline for improvement measure and identify if trend exist within target conditions. **Data Source:** EHR Process Milestone 3 Estimated Incentive Payment: $58,759	**Outcome Improvement Target 1**[IT-9.2] Reduce ED visits for targeted conditions identified in DY3 **Improvement Target**: TBD% decrease in ED Visits over DY 3 Baseline **Data Source:** EHR Improvement Target 1 Estimated Incentive Payment: $186,854	**Outcome Improvement Target 2** IT-9.2] Reduce ED visits for targeted conditions identified in DY3 **Improvement Target**: TBD% decrease in ED Visits over DY 3 Baseline **Data Source:** EHR Improvement Target 2 Estimated Incentive Payment: $443,965
Year 2 Estimated Outcome Amount: $102,190	Year 3 Estimated Outcome Amount: $117,518	Year 4 Estimated Outcome Amount: $186,854	Year 5 Estimated Outcome Amount: $443,965
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $850,527			

Identifying Outcome Measure and Provider Information:
Outcome Measure: 3.IT-6.1 Patient Satisfaction
Unique Identifier: 138364812.3.1
Performing Provider: Permian Basin Community Centers (PBCC)/138364812

Outcome Measure Description:

PBCC selects Patient Satisfaction as a desired outcome for individuals served in **Project 1.1 – Expand Specialty Care.** Process milestones include project planning for purposes of engaging local stakeholders, identifying current capacity and needed resources, determining timelines, and documenting a solid implementation plan. Project planning will be PBCC's main focus relating to expanding specialty care services in DY 2.

Starting in DY 3, PBCC will conduct Plan Do Study Act (PDSA) activities. Outcome improvement targets were established for DY 4 and 5 focusing on improvement in patient satisfaction scores. Percentage targets were set at 30% and 40% in DY 4 and 5 respectively. The focus will be to ensure that individuals are getting timely care, receiving effective communication from their physicians, have adequate access, are involved in their treatment, and that their overall health and functioning is improved to the fullest extent possible. In addition to the Rationale (stated below) for selecting Patient Satisfaction as an Outcome measure, this measure was also selected by PBCC because PBCC has the ability to produce that data at this time.

As stated in the description of PBCC Project 1.1, Option 1.9.2, treating the behavioral health needs of this targeted population **will reduce Potentially Preventable Hospital Admissions and Readmissions**. However, currently, PBCC does not have access to hospital admission data and so cannot report the improvement that will be realized. PBCC hopes to partner with the region's hospitals to develop this reporting capability.

Rationale:

Patient satisfaction surveys are designed to produce comparable data on the patients' perspectives of care that allows for objective and meaningful comparisons between institutions on domains that are important to individuals. Public reporting and sharing of survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

A recent study reported the association between patient satisfaction and mortality rates after adjusting for clinical quality. Higher patient satisfaction was associated with lower mortality even after controlling for adherence to evidence-based practice guidelines, demonstrating that patients can judge the quality of clinical care they receive. Patient satisfaction is not about making patients "happy". It is about improving the patients experience to facilitate health and medical outcomes. When patients are satisfied, trust is enhanced. When patients trust their physician, they are more likely to disclose information, follow advice and adhere to treatment plans. Improving patient satisfaction also helps to ensure that people don't avoid getting the care they need which could prevent larger health issues in the future.

(Press Ganey, "How Patient Satisfaction Correlates with Clinical Quality" by Maxwell Drain, MA, April 12, 2010).

PBCC will be working with other Community Centers in learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIE's or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Outcome Measure Valuation:

PBCC used the method of cost-utility analysis for valuing its Outcome Measure of OD 6 Patient Satisfaction related to Project 1.1 (Expanding Specialty Care). This method measures the cost of the proposed program in dollars and the health consequences in utility-weighted units. The valuation applies **quality-adjusted life-years (QALYs)** analysis that combines health quality (utility) with length of time in a particular health state. **See Attachment 4 in the Addendum - Rationale for Economic Valuation**. This valuation was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.

For this project, the intervention of providing mental health services to individuals with no current access to care (since they do not meet public health funding eligibility due to diagnostic criteria) was assumed to bring a QALY gain of .335. To this QALY was applied a monetary value of $50,000 per life-year gained, for a valuation of $5,410,250 for the estimated number of 323 indigent persons to be served. By increasing the QALY, Patient Satisfaction would increase and hospitalizations and mortality rates would decrease.

In addition to the above, two more valuation calculations were explained in the Valuation section of Project 1.9.2. ,which substantiate that this Outcome Measure should be valued at no less than the $511,967 requested as potential incentive payment.

138364812.3.1	*3.IT-6.1*	***PATIENT SATISFACTION***	
Permian Basin Community Centers			*138364812*
Related Category 1 or 2 Projects:	*138364812.1.1*		
Starting Point/Baseline:	PBCC's baseline for project 1-1.1 is zero as there are no specialty behavioral health clinics for indigent or underfunded individuals in the Permian Basin as of October 1, 2012; therefore, there is no patient satisfaction data to assess.		
Year 2 (10/1/2012 – 9/30/2013)	**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: **(Cat 3,pg 363, P-1)** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2: (Cat 3, pg. 363, P-4)** Conduct Plan Do Study ACT (PDSA) cycles to improve data collection and intervention activities Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Process Milestone 2 Estimated Incentive Payment: $115,267	**Outcome Improvement Target 1**: OD-6 **Improvement Target: IT-6.1)** 30**%** improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific evidence based tool. Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $124,422	**Outcome Improvement Target 2** OD-6 **Improvement Target: IT-6.1** 40% Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool evidence-based tool. Data Source: Patient survey : Outcome Improvement Target 2 Estimated Incentive Payment*:* $272,278
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $115,267	Year 4 Estimated Outcome Amount: $124,422	Year 5 Estimated Outcome Amount: $272,278
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $511,967			

Identifying Outcome Measure and Provider Information:
Outcome Measure: 3. IT-10.1 Quality of Life
Unique Identifier: 138364812.3.2
Performing Provider: Permian Basin Community Centers (PBCC)/138364812

Outcome Measure Description:

PBCC selects Quality of Life (QOL) improvement as a desired outcome for individuals served. Process milestones include project planning for purposes of engaging local stakeholders, identifying current capacity and needed resources, determining timelines, and documenting a solid implementation plan. Project planning will be PBCC's main focus relating to **Project** 1.2 (Enhancing Service Availability of Appropriate Levels of Behavioral Health Care), and **Project 2.1**(Integrating Primary and Behavioral Health Care Services).

Starting in DY 3, PBCC will conduct Plan Do Study Act (PDSA) activities in order to improve data collection and intervention activities for purposes of ensuring successful implementation of projects relating to enhancing service availability and integrating primary and behavioral health care services. Outcome improvement targets were selected for DY 4 and 5 to focus on improvement in QOL scores as measured by evidence based and validated assessment tools for the target population, but the actual percentage of improvement will be determined in DY 3. In addition to the Rationale (stated below) for selecting Quality of Life as an Outcome Measure, this measure was also selected by PBCC because PBCC has the ability to produce that data at this time.

As stated in the description of PBCC Project 1.2, Option 1.12.4, treating the behavioral health needs of this targeted population **will reduce Potentially Preventable Hospital Admissions and Readmissions**. However, currently, PBCC does not have access to hospital admission data and so cannot report the improvement that will be realized. PBCC hopes to partner with the region's hospitals to develop this reporting capability.

PBCC will also be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIE's or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

Although much of health care is focused on increasing longevity, many treatments are specifically designed to improve symptoms and functions, two essential components of health related to quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. Project planning and conducting Plan Do Study Act (PDSA) are essential in laying the ground work for the development of successful demonstration projects that are designed to operate under continuous improvement monitoring.

Data will be collected in simple interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purpose of improvement.

There is evidence that Health Related Quality of Life (HRQOL) predicts outcomes among patients. A study of 1,000 patients at three dialysis facilities in the United States reported an association between lower scores in the physical component of quality of life and higher risk of death and hospitalization. A larger study, involving 5,256 patients at 243 facilities in the United States and Europe presented evidence that psychological or mental components of quality of life predict death in hemodialysis patients. Self – reported depression was significantly associated with a higher risk of death and hospitalization (Kidney International, "Health Related Quality of Life, as a predictor of mortality and hospitalization: The Dialysis Outcomes Practice and Patterns Study (DOPPS), *Kidney International* (2003) 64, 339–349; doi:10.1046/j.1523-1755.2003.00072). It is PBCC's contention that the same principles apply to behavioral health and other primary care ailments, and that affecting QOL will improve patient outcome and output measures leading to decreased utilization of costly inpatient and emergency medical care.

Outcome Measure Valuation:

PBCC used the method of cost-utility analysis for valuing its Outcome Measure of OD 10.1 **Quality of Life** related to both Project 1.2 (Enhancing Service Availability to Appropriate Levels of Behavioral Health) and 2.1 (Integration of Behavioral Health and Primary Care). This method measures the cost of the proposed programs in dollars and the health consequences in utility-weighted units. It was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation applies **quality-adjusted life-years (QALY's**) analysis that combines health quality (utility) with length of time in a particular health state. **See Addendum 4 – Rationale for Economic Valuation.**

For Project 1.2 the QALY gained was .11135, and a monetary value of $50,000 was assigned per life-year gained due to the intervention.

For Project 1.2 the valuation for the project to achieve its outcome measure of improved Quality of Life was $1,336,200 annually. This project to bring additional substance abuse treatment (Community Needs Assessment CN.1, CN.2, CN.6) to an indigent population should be valued then at no less than the amount of $530,246 requested as potential incentive payment.

Additional valuation methods are explained in the Valuation section of each Project. These further substantiate the value being requested as incentive payments.

138364812.3.2	*3.IT-10.1*	***QUALITY OF LIFE***	
Permian Basin Community Centers (PBCC)			*138364812*
Related Category 1 or 2 Projects:	*138364812.**1.2***		
Starting Point/Baseline:	PBCC's baseline for project 1.2 was 402 individuals for FY 12. The behavioral health expansion project will open doors to individuals who do not have access to services currently. Baseline QOL for this population is currently zero or unknown. QOL data will be obtained at time of admission and discharge from the expansion unit.		
Year 2 (10/1/2012 – 9/30/2013)	**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: **(Cat 3,pg 363, P-1)** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2: (Cat 3, pg. 363, P-4)** Conduct Plan Do Study ACT (PDSA) cycles to improve data collection and intervention activities Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Process Milestone 2 Estimated Incentive Payment: $122,885	**Outcome Improvement Target 1:** OD -10 Quality of Life **Improvement Target: IT-10.1** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for target population. Actual percentage is TBD. Data Source: results of validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL Outcome Improvement Target 1 Estimated Incentive Payment*:* $129,595	**Outcome Improvement Target 2:** OD -10 Quality of Life **Improvement Target: IT-10.1:** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for target population. Actual percentage is TBD. Data Source: results of validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL Outcome Improvement Target 2 Estimated Incentive Payment*:* $277,766
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $122,885	Year 4 Estimated Outcome Amount: $129,595	Year 5 Estimated Outcome Amount: $277,766
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $530,246			

Identifying Outcome Measure and Provider Information:
Outcome Measure: Quality of Life 3.IT-10.1
Unique Identifier: 138364812.3.3
Performing Provider: Permian Basin Community Centers (PBCC)/138364812

Outcome Measure Description:

PBCC selects Quality of Life (QOL) improvement as a desired outcome for individuals served. Process milestones include project planning for purposes of engaging local stakeholders, identifying current capacity and needed resources, determining timelines, and documenting a solid implementation plan. Project planning will be PBCC's main focus relating to **Project** 1.2 (Enhancing Service Availability of Appropriate Levels of Behavioral Health Care), and **Project 2.1**(Integrating Primary and Behavioral Health Care Services).

Starting in DY 3, PBCC will conduct Plan Do Study Act (PDSA) activities in order to improve data collection and intervention activities for purposes of ensuring successful implementation of projects relating to enhancing service availability and integrating primary and behavioral health care services. Outcome improvement targets were selected for DY 4 and 5 to focus on improvement in QOL scores as measured by evidence based and validated assessment tools for the target population, but the actual percentage of improvement will be determined in DY 3. In addition to the Rationale (stated below) for selecting Quality of Life as an Outcome Measure, this measure was also selected by PBCC because PBCC has the ability to produce that data at this time.

As stated in the description of PBCC Project 2.1, Option 2.15.1, treating the primary care and behavioral health needs of this targeted population **will reduce Potentially Preventable Hospital Admissions and Readmissions**. However, currently, PBCC does not have access to hospital admission data and so cannot report the improvement that will be realized. PBCC hopes to partner with the region's hospitals to develop this reporting capability.

PBCC will also be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIE's or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

Although much of health care is focused on increasing longevity, many treatments are specifically designed to improve symptoms and functions, two essential components of health related to quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. Project planning and conducting Plan Do Study Act (PDSA) are essential in laying the ground work for the development of successful demonstration projects that are designed to operate under continuous improvement monitoring.

Data will be collected in simple interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purpose of improvement.

There is evidence that Health Related Quality of Life (HRQOL) predicts outcomes among patients. A study of 1,000 patients at three dialysis facilities in the United States reported an association between lower scores in the physical component of quality of life and higher risk of death and hospitalization. A larger study, involving 5,256 patients at 243 facilities in the United States and Europe presented evidence that psychological or mental components of quality of life predict death in hemodialysis patients. Self – reported depression was significantly associated with a higher risk of death and hospitalization (Kidney International, "Health Related Quality of Life, as a predictor of mortality and hospitalization: The Dialysis Outcomes Practice and Patterns Study (DOPPS), *Kidney International* (2003) 64, 339–349; doi:10.1046/j.1523-1755.2003.00072). It is PBCC's contention that the same principles apply to behavioral health and other primary care ailments, and that affecting QOL will improve patient outcome and output measures leading to decreased utilization of costly inpatient and emergency medical care.

Outcome Measure Valuation:

PBCC used the method of cost-utility analysis for valuing its Outcome Measure of OD 10.1 **Quality of Life** related to both Project 1.2 (Enhancing Service Availability to Appropriate Levels of Behavioral Health) and 2.1 (Integration of Behavioral Health and Primary Care). This method measures the cost of the proposed programs in dollars and the health consequences in utility-weighted units. It was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation applies **quality-adjusted life-years (QALY's**) analysis that combines health quality (utility) with length of time in a particular health state. **See Addendum 4 – Rationale for Economic Valuation.**

For Project 2.1 the QALY gained was .335, and a monetary value of $50,000 was assigned per life-year gained due to the intervention.

For Project 2.1, the valuation for the project to achieve its outcome measure of improved Quality of Life was $8,040,000 annually. This project to integrate primary care into a public mental health clinic for severely and persistently mentally ill addresses Community Needs CN.1, CN.2, and CN.3, and should be valued at no less than the amount of $972,007 requested as potential incentive payment.

Additional valuation methods are explained in the Valuation section of each Project. These further substantiate the value being requested as incentive payments.

138364812.3.3	*3.IT-10.1*	***QUALITY OF LIFE***	
Permian Basin Community Centers (PBCC)			*138364812*
Related Category 1 or 2 Projects:	*138364812.2.1*		
Starting Point/Baseline:	PBCC's baseline for project 2.1 is zero as there are no integrated clinics in the Permian Basin as of October 1, 2012; therefore, there is no QOL data to assess. Baseline QOL for this population is currently zero or unknown. QOL data will be obtained at time of admission and discharge from the expansion unit.		
Year 2 (10/1/2012 – 9/30/2013)	**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: **(Cat 3,pg 363, P-1)** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $-0-	**Process Milestone 2: (Cat 3, pg. 363, P-4)** Conduct Plan Do Study ACT (PDSA) cycles to improve data collection and intervention activities Data Source: **(Cat 2, pg. 321)** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Process Milestone 2 Estimated Incentive Payment: $220,077	**Outcome Improvement Target 1:** OD-10 Quality of Life **Improvement Target:** **IT-10.1** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for target population. Percentage of improvement is TBD. Data Source: results of validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL Outcome Improvement Target 1 Estimated Incentive Payment*:* $236,246	**Outcome Improvement Target 2:** OD-10 Quality of Life **Improvement Target:** **IT-10.1** Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for target population. Actual percentage of improvement is TBD. Data Source: results of validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL Outcome Improvement Target 2 Estimated Incentive Payment*:* $515,684

138364812.3.3	*3.IT-10.1*	***QUALITY OF LIFE***	
Permian Basin Community Centers (PBCC)			*138364812*
Related Category 1 or 2 Projects:	*138364812.2.1*		
Starting Point/Baseline:	PBCC's baseline for project 2.1 is zero as there are no integrated clinics in the Permian Basin as of October 1, 2012; therefore, there is no QOL data to assess. Baseline QOL for this population is currently zero or unknown. QOL data will be obtained at time of admission and discharge from the expansion unit.		
Year 2 (10/1/2012 – 9/30/2013)	**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: (add incentive payments amounts from each milestone/outcome improvement target): $-0-	Year 3 Estimated Outcome Amount: $220,077	Year 4 Estimated Outcome Amount: $236,246	Year 5 Estimated Outcome Amount: $515,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $972,007			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD-1 Primary Care Prevention; Percent Improvement over Baseline for IT.1.12 Diabetes Care Retinal Eye Exam
Unique Identifier: 112684904.3.1
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

As noted on Table Y in the appendix of the attached Regional Healthcare Partnership 14 Community Needs Assessment, between the years of 2005 to 2010 Region 14 had 3,011 potentially preventable Hospital admissions associated with both short term and long term diabetes related complications. This resulted in $66,064,959 of Hospital charges that could have potentially been eliminated. Additionally, as noted on Table X Page 22 of the Regional Healthcare Partnership 14 Community Needs Assessment, it is estimated that 10% of the adult population age 20 and above have either type 1 or type 2 diabetes.

Reeves County Hospital District primarily serves Reeves County where it is estimated that approximately 1,376 citizens have been diagnosed with type 1 or type 2 diabetes. In order to optimally manage modifiable risk factors for those individuals, Reeves County Hospital District has selected the following three Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures in year four and five of the waiver. Our numerators for these measures will be the percent improvement in the targeted patient population over baseline established in year three of the waiver.

Rationale:

For year two of the Waiver the Hospital District has selected P-3 Develop and Test Data Systems, as currently no method exist for gathering numerator and denominator data that will needed to measure improvement efforts in years four and five of the Waiver.

Additionally, after a data collection system has been developed the Hospital District has selected P- 3.2 Establish Baseline Rates for year three of the Waiver. This will establish the baseline rates that will be used to measure improvement in years four and five of the Waiver.

Furthermore, the Hospital District also selected P-3.5 Disseminate Finding to Stakeholders for year three of the Waiver. The purpose of selecting this measure is to involve stakeholders in order to establish a top down approach for future improvement efforts.

Lastly, for years four and five of the waiver to demonstrate improved performance, Reeves County Hospital District has selected the following three Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures in year four and five of the Waiver.

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment

4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District- Diabetes Quality Enhancement Program received a ranking of 7 points out of the 24 possible points available. As a result for each year under the waiver 29% (7/24 =.29 or 29%) of Category 3 available funds will be allocated to the Diabetes Quality Enhancement Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure in that given year.

112684904.3.1	*3.IT.1.12*	*Diabetes Care Retinal Eye Exam*	
Reeves County Hospital District			112684904
Related Category 1 or 2 Projects	*112684901.2.1*		
Starting Point/Baseline	New Project		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-3]: Develop and Test Data Systems Data Source: EHR, Registry, Claims, Administrative clinical data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,552	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: EHR, Registry, Claims, Administrative clinical data Process Milestone 2 Estimated Incentive Payment: $7,434 Process Milestone 3 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Submission of findings Process Milestone 2 Estimated Incentive Payment: $7,434	**Outcome Improvement Target 1** [IT-12]: Improvement Target: Diabetes care- Retinal eye exam test increase by 5% over baseline **Numerator:** An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year **Denominator:** Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Data Source:** EHR, Registry, Claims, Administrative clinical data **Outcome Improvement Target 1**	**Outcome Improvement Target 2** [IT-12]: Improvement Target: Diabetes care- Retinal eye exam test increase by 10% over baseline Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year Denominator: Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 3 Estimated Incentive Payment: $38,036

		Estimated Incentive Payment: $21,208	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $8,552	Year 3 Estimated Outcome Amount: $14,868	Year 4 Estimated Outcome Amount: $21,208	Year 5 Estimated Outcome Amount: $38,036
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $82,664			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD-1 Primary Care Prevention; Percent Improvement over Baseline for IT.1.13 Diabetes Care Foot Exam
Unique Identifier: 112684904.3.2
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

As noted on Table Y in the appendix of the attached Regional Healthcare Partnership 14 Community Needs Assessment, between the years of 2005 to 2010 Region 14 had 3,011 potentially preventable Hospital admissions associated with both short term and long term diabetes related complications. This resulted in $66,064,959 of Hospital charges that could have potentially been eliminated. Additionally, as noted on Table X Page 22 of the Regional Healthcare Partnership 14 Community Needs Assessment, it is estimated that 10% of the adult population age 20 and above have either type 1 or type 2 diabetes.

Reeves County Hospital District primarily serves Reeves County where it is estimated that approximately 1,376 citizens have been diagnosed with type 1 or type 2 diabetes. In order to optimally manage modifiable risk factors for those individuals, Reeves County Hospital District has selected the following three Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures in year four and five of the waiver. Our numerators for these measures will be the percent improvement in the targeted patient population over baseline established in year three of the waiver.

Rationale:

For year two of the Waiver the Hospital District has selected P-3 Develop and Test Data Systems, as currently no method exist for gathering numerator and denominator data that will needed to measure improvement efforts in years four and five of the Waiver.
Additionally, after a data collection system has been developed the Hospital District has selected P- 3.2 Establish Baseline Rates for year three of the Waiver. This will establish the baseline rates that will be used to measure improvement in years four and five of the Waiver.
Furthermore, the Hospital District also selected P-3.5 Disseminate Finding to Stakeholders for year three of the Waiver. The purpose of selecting this measure is to involve stakeholders in order to establish a top down approach for future improvement efforts.
Lastly, for years four and five of the waiver to demonstrate improved performance, Reeves County Hospital District has selected the following three Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures in year four and five of the Waiver.

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment

4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District- Diabetes Quality Enhancement Program received a ranking of 7 points out of the 24 possible points available. As a result for each year under the waiver 29% (7/24 =.29 or 29%) of Category 3 available funds will be allocated to the Diabetes Quality Enhancement Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure in that given year.

112684904.3.2	*3.IT.1.13*	*Diabetes Care Foot Exam*	
Reeves County Hospital District			112684904
Related Category 1 or 2 Projects	*112684901.2.1*		
Starting Point/Baseline	New Project		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-3]: Develop and Test Data Systems Data Source: EHR, Registry, Claims, Administrative clinical data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,551	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: EHR, Registry, Claims, Administrative clinical data Process Milestone 2 Estimated Incentive Payment: $7,434 Process Milestone 3 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Submission of findings Process Milestone 2 Estimated Incentive Payment: $7,434	**Outcome Improvement Target 1** [IT-13]: Diabetes Care Foot Exam Improvement Target: IT-1.13: Diabetes care-Foot exam test increase by 5% over baseline Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment:	**Outcome Improvement Target 2** [IT-13]: Diabetes Care Foot Exam Improvement Target: IT-1.13: Diabetes care-Foot exam test increase by 10% over baseline Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 5 Estimated Incentive Payment: $38,036

		$21,208	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $8,551	Year 3 Estimated Outcome Amount: $14,868	Year 4 Estimated Outcome Amount: $21,208	Year 5 Estimated Outcome Amount: $38,036
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $82,663			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD-1 Primary Care Prevention; Percent Improvement over Baseline for IT.1.14 Diabetes Care Microalbumin/Nephropathy
Unique Identifier: 112684904.3.3
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

As noted on Table Y in the appendix of the attached Regional Healthcare Partnership 14 Community Needs Assessment, between the years of 2005 to 2010 Region 14 had 3,011 potentially preventable Hospital admissions associated with both short term and long term diabetes related complications. This resulted in $66,064,959 of Hospital charges that could have potentially been eliminated. Additionally, as noted on Table X Page 22 of the Regional Healthcare Partnership 14 Community Needs Assessment, it is estimated that 10% of the adult population age 20 and above have either type 1 or type 2 diabetes.

Reeves County Hospital District primarily serves Reeves County where it is estimated that approximately 1,376 citizens have been diagnosed with type 1 or type 2 diabetes. In order to optimally manage modifiable risk factors for those individuals, Reeves County Hospital District has selected the following three Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures in year four and five of the waiver. Our numerators for these measures will be the percent improvement in the targeted patient population over baseline established in year three of the waiver.

Rationale:

For year two of the Waiver the Hospital District has selected P-3 Develop and Test Data Systems, as currently no method exist for gathering numerator and denominator data that will needed to measure improvement efforts in years four and five of the Waiver.

Additionally, after a data collection system has been developed the Hospital District has selected P- 3.2 Establish Baseline Rates for year three of the Waiver. This will establish the baseline rates that will be used to measure improvement in years four and five of the Waiver. Furthermore, the Hospital District also selected P-3.5 Disseminate Finding to Stakeholders for year three of the Waiver. The purpose of selecting this measure is to involve stakeholders in order to establish a top down approach for future improvement efforts.

Lastly, for years four and five of the waiver to demonstrate improved performance, Reeves County Hospital District has selected the following three Non-Stand Alone Measures: OD-1 IT.1.12; IT.1.13; IT 1.14 as outcome measures in year four and five of the Waiver.

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment

4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District- Diabetes Quality Enhancement Program received a ranking of 7 points out of the 24 possible points available. As a result for each year under the waiver 29% (7/24 =.29 or 29%) of Category 3 available funds will be allocated to the Diabetes Quality Enhancement Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure in that given year.

112684904.3.3	*3.IT.1.14*	*Diabetes Care Microalbumin/Nephropathy*	
Reeves County Hospital District			112684904
Related Category 1 or 2 Projects	*112684901.2.1*		
Starting Point/Baseline	New Project		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-3]: Develop and Test Data Systems Data Source: EHR, Registry, Claims, Administrative clinical data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,551	**Process Milestone 2 [P-2]: Establish Baseline Rates** Data Source: EHR, Registry, Claims, Administrative clinical data Process Milestone 2 Estimated Incentive Payment: $7,434 Process Milestone 3 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Submission of findings Process Milestone 2 Estimated Incentive Payment: $7,434	**Outcome Improvement Target 1** [IT-14]: Improvement Target: IT-1.14: Diabetes care-Microalbumin/Nephropathy Screening or Testing increase by 5% over baseline Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment: $21,208	**Outcome Improvement Target 2** [IT-14]: Improvement Target: IT-1.14: Diabetes care-Microalbumin/Nephropathy Screening or Testing increase by 10% over baseline Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 2 Estimated Incentive Payment: $38,036
Year 2 Estimated Outcome Amount: (add incentive payments amounts	Year 3 Estimated Outcome Amount: $14,868	Year 4 Estimated Outcome Amount: $21,208	Year 5 Estimated Outcome Amount: $38,036

from each milestone/outcome improvement target): $8,551			
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $82,663			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD12 Primary Care and Prevention IT 12.1 Breast Cancer Screening
Unique Identifier: 112684904.3.4
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

Through the opportunity provided by the 1115B, Reeves County Hospital District would like to move from a focus on sickness and disease to one based on wellness and prevention. As noted in the Appendix of the Regional Healthcare Partnership 14 Community Needs Assessment on Table S page 19; 35% of women 40 years and older have not had a mammogram in the past two years, and 29% of women 18 years and older have had no pap smear within the last three years, 84% of men and women 50 years and older have had no Fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. As it relates to the percentage of these services provided to the population as a whole, the Region is currently performing worse than both the Federal and State numbers. It is for this reason in Category Three, Reeves County Hospital District has selected outcome improvement domain OD-12.1 Primary Care and Primary Prevention. In this domain the Hospital District has chosen to focus on the three following non-standalone measures.

1. IT-12.1 Breast Cancer Screening
2. IT-12.2 Cervical Cancer Screening
3. IT-12.3 Colorectal Cancer Screening.

For each of these standalone measures, the Hospital District will attempt to improve the total number of people within the Hospitals target area that have received the above mention cancer screenings.

Rationale:

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. Currently, no data exist on the percentage of patients Reeves County Hospital District provides service to, that receive colon, breast, and cervical cancer screenings. For this reason, Reeves County Hospital District has selected P-3.3 Develop and Test Data Systems and P-3.2 Establish baseline rates as its process measures for years two and three. Additionally, in order to measure performance, the Hospital District in years four and five has selected OD 12 Primary Care and Prevention as its Category 3 outcome measures.
All other Process Milestones under Category 3 are either not needed or not applicable to the Hospitals Patient Experience Improvement Initiative

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs

2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District- Cancer Prevention Program received a ranking of 11 points out of the 24 possible points available. As a result for each year under the waiver 46% (11/24 =.46 or 46 %) of Category 3 available funds will be allocated to the Cancer Prevention Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure identified in that given year.

Milestones and Metrics Table

112684904.3.4	*3. IT-12.1*	*Breast Cancer Screening*	
Reeves County Hospital District		*112684904*	
Related Category 2 Projects:	*Unique Category 2 Project Identifier: 112684904.2.2*		
Starting Point/Baseline:	*To be developed in Year 3*		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-3]: Develop and Test Data Systems **Data Source:** Documentation of methods used and data collected from Test **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $13,565	**Process Milestone 2 [P-2]** Establish a Baseline for the following: **Breast Cancer Screening** **Numerator:** Number of women aged 40 to 69 that have received an annual Mammogram during the reporting period. **Denominator:** Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded **Data Source:** EHR, Claims **Process Milestone 2 Estimated Incentive Payment *(maximum amount):*** $23,585	**Outcome Improvement Target 1** [IT-12.1]: Increase Breast Cancer Screening by 5% over baseline (HEDIS 2012) (Non-standalone measure) **Numerator:** Number of women aged 40 to 69 that have received an annual Mammogram during the reporting period. **Denominator:** Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded **Data Source:** EHR, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 33,640	**Outcome Improvement Target 2** [IT-12.1]: Increase Breast Cancer Screening by 10% over baseline (HEDIS 2012) (Non-standalone measure) **Numerator:** Number of women aged 40 to 69 that have received an annual Mammogram during the reporting period. **Denominator:** Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded **Data Source:** EHR, Claims **Outcome Improvement Target 4 Estimated Incentive Payment*:*** $60,333
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $13,565	Year 3 Estimated Outcome Amount: $23,585	Year 4 Estimated Outcome Amount: $33,640	Year 5 Estimated Outcome Amount: $60,333
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $131,123			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD12 Primary Care and Prevention IT 12.2 Cervical Cancer Screening
Unique Identifier: 112684904.3.5
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

Through the opportunity provided by the 1115B, Reeves County Hospital District would like to move from a focus on sickness and disease to one based on wellness and prevention. As noted in the Appendix of the Regional Healthcare Partnership 14 Community Needs Assessment on Table S page 19; 35% of women 40 years and older have not had a mammogram in the past two years, and 29% of women 18 years and older have had no pap smear within the last three years, 84% of men and women 50 years and older have had no Fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. As it relates to the percentage of these services provided to the population as a whole, the Region is currently performing worse than both the Federal and State numbers. It is for this reason in Category Three, Reeves County Hospital District has selected outcome improvement domain OD-12.1 Primary Care and Primary Prevention. In this domain the Hospital District has chosen to focus on the three following non-standalone measures.

1. IT-12.1 Breast Cancer Screening
2. IT-12.2 Cervical Cancer Screening
3. IT-12.3 Colorectal Cancer Screening.

For each of these non-standalone measures, the Hospital District will attempt to improve the total number of people within the Hospitals target area that have received the above mention cancer screenings.

Rationale:

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. Currently, no data exist on the percentage of patients Reeves County Hospital District provides service to, that receive colon, breast, and cervical cancer screenings. For this reason, Reeves County Hospital District has selected P-3.3 Develop and Test Data Systems and P-3.2 Establish baseline rates as its process measures for years two and three. Additionally, in order to measure performance, the Hospital District in years four and five has selected OD 12 Primary Care and Prevention as its Category 3 outcome measures.

All other Process Milestones under Category 3 are either not needed or not applicable to the Hospitals Patient Experience Improvement Initiative

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs

2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.

The Reeves County Hospital District- Cancer Prevention Program received a ranking of 11 points out of the 24 possible points available. As a result for each year under the waiver 46% (11/24 =.46 or 46 %) of Category 3 available funds will be allocated to the Cancer Prevention Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure identified in that given year.

Milestones and Metrics Table:

112684904.3.5	***OD -12, IT-12.2***	***Cervical Cancer Screening***	
Reeves County Hospital District		***112684904***	
Related Category 2 Projects:	***Unique Category 2 Project Identifier: 112684904.2.2***		
Starting Point/Baseline:	***To be developed in Year 3***		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-3]: Develop and Test Data Systems **Data Source:** Documentation of methods used and data collected from Test **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $13,565	**Process Milestone 2 [P-2]** Establish a Baseline for the following: **Cervical Cancer Screening** **Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. **Denominator:** Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded. **Data Source:** EHR, Claims **Process Milestone 2 Estimated Incentive Payment *(maximum amount):*** $23,585	**Outcome Improvement Target 1** [IT-12.2]: Increase Cervical Cancer Screening by 5% over baseline (HEDIS 2012) (Non-standalone measure) **Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. **Denominator:** Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded. **Data Source:** EHR, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 33,640	**Outcome Improvement Target 2** [IT-12.2]: Increase Cervical Cancer Screening by 10% over baseline(HEDIS 2012) (Non-standalone measure) **Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. **Denominator:** Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded. **Data Source:** EHR, Claims **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $60,333
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $13,565	Year 3 Estimated Outcome Amount: $23,585	Year 4 Estimated Outcome Amount: $33,640	Year 5 Estimated Outcome Amount: $60,333
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $131,123			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD12 Primary Care and Prevention IT 12.3 Colorectal Cancer Screening
Unique Identifier: 112684904.3.6
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

Through the opportunity provided by the 1115B, Reeves County Hospital District would like to move from a focus on sickness and disease to one based on wellness and prevention. As noted in the Appendix of the Regional Healthcare Partnership 14 Community Needs Assessment on Table S page 19; 35% of women 40 years and older have not had a mammogram in the past two years, and 29% of women 18 years and older have had no pap smear within the last three years, 84% of men and women 50 years and older have had no Fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. As it relates to the percentage of these services provided to the population as a whole, the Region is currently performing worse than both the Federal and State numbers. It is for this reason in Category Three, Reeves County Hospital District has selected outcome improvement domain OD-12.1 Primary Care and Primary Prevention. In this domain the Hospital District has chosen to focus on the three following non-standalone measures.

1. IT-12.1 Breast Cancer Screening
2. IT-12.2 Cervical Cancer Screening
3. IT-12.3 Colorectal Cancer Screening.

For each of these non-standalone measures, the Hospital District will attempt to improve the total number of people within the Hospitals target area that have received the above mention cancer screenings.

Rationale:

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. Currently, no data exist on the percentage of patients Reeves County Hospital District provides service to, that receive colon, breast, and cervical cancer screenings. For this reason, Reeves County Hospital District has selected P-3.3 Develop and Test Data Systems and P-3.2 Establish baseline rates as its process measures for years two and three. Additionally, in order to measure performance, the Hospital District in years four and five has selected OD 12 Primary Care and Prevention as its Category 3 outcome measures.

All other Process Milestones under Category 3 are either not needed or not applicable to the Hospitals Patient Experience Improvement Initiative

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs

2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.
The Reeves County Hospital District- Cancer Prevention Program received a ranking of 11 points out of the 24 possible points available. As a result for each year under the waiver 46% (11/24 =.46 or 46 %) of Category 3 available funds will be allocated to the Cancer Prevention Program. Additionally, for each year of the Waiver, funds will be equally divided by each Improvement or Outcome Measure identified in that given year.

Milestones and Metrics Table:

112684904.3.6	*OD -12, IT-12.3*	*Colorectal Cancer Screening*	
Reeves County Hospital District		*112684904*	
Related Category 2 Projects:	*Unique Category 2 Project Identifier: 112684904.2.2*		
Starting Point/Baseline:	*To be developed in Year 3*		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1 [P-3]: Develop and Test Data Systems **Data Source:** Documentation of methods used and data collected from Test **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $13,565	**Process Milestone 2 [P-2]** Establish a Baseline for the following: **Colorectal Cancer Screening** **Numerator:** Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years **Denominator:** Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. **Data Source:** EHR, Claims **Process Milestone 2 Estimated Incentive Payment *(maximum amount):*** $23,585	**Outcome Improvement Target 1** [IT-12.3] Increase Colorectal Cancer Screening by 5% over baseline (HEDIS 2012) (Non-standalone measure) **Numerator:** Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years **Denominator:** Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. **Data Source:** EHR, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 33,640	**Outcome Improvement Target 2** [IT-12.3] Increase Colorectal Cancer Screening by 10% over baseline (HEDIS 2012) (Non-standalone measure) **Numerator:** Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years **Denominator:** Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. **Data Source:** EHR, Claims **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $60,333

Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $13,565	Year 3 Estimated Outcome Amount: $23,585	Year 4 Estimated Outcome Amount: $33,640	Year 5 Estimated Outcome Amount: $60,333
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $131,123			

Identifying Outcome Measure and Provider Information:
Outcome Measure: IT.6.1 Percent Improvement over Baseline of Patient Satisfactions Scores
Unique Identifier: 112684904.3.7
Performing Provider: Reeves County Hospital District/TPI: 112684904

Outcome Measure Description:

In 2011, the Pecos Valley Rural Health Clinic (owned and operated by Reeves County Hospital District) provided 15,962 total patient primary care visits to the citizens of Reeves County and surrounding areas. Based on this data, Reeves County Hospital District is currently meeting the primary health care needs of the community it serves. However, in order to maintain this standard the Hospital must now shift its focus to improving the overall quality of services provided, as measured by the patients the Clinic serves. It is for this reason in years 4 and 5 of the Waiver Reeves County Hospital District has selected outcome improvement measure IT 6.1 Percent Improvement over Baseline of Patient Satisfaction. Patient satisfactions surveys will be administered during Years 2-5 of the Waiver and will be the baseline for focusing future improvement efforts.

Rationale:

For year two of the Waiver the Hospital District has selected P-3.2 Establish a Baseline Rate, as patient satisfaction surveys will not commence until year two of the Waiver. Year two will be utilized to identify the focus of Hospital improvement efforts in subsequent years of the Waiver.

Additionally, in order to involve stakeholders and to allow significant time collect statistically valid data, Reeves County Hospital District has selected P-3.5 Disseminate Finding to Stakeholders for year three of the Waiver. The purpose of selecting this measure is to establish a top down approach for future improvement efforts.

Lastly, for year four of the waiver to demonstrate improved performance, Reeves County Hospital District has selected IT -6.1 5% Percent Improvement over Baseline for standalone measures 6.1.1, 6.1.2, and 6.1.4. For year five of the waiver to demonstrate improved performance, Reeves County Hospital District has selected IT -6.1 10% Percent Improvement over Baseline for standalone measures 6.1.1, 6.1.2, and 6.1.4.

All other Process Milestones under Category 3 are either not needed or not applicable to the Hospitals Patient Experience Improvement Initiative.

Outcome Measure Valuation:

For each measure under Category 3 the Hospital District used the same valuation Model as it did for Category 2 projects. An explanation of the valuation model used is provided below. Reeves County Hospital District valued each project based on the four criteria below:

1. Addresses Community Needs
2. Population Served
3. Project Investment
4. Staff Time required to Meet Process and Outcome Milestones.

Each project received a ranking from 1-3 (three being the highest) based on which best met the criteria identified above. For each ranking received, the project received the same number

of points. There are a total of 24 points available for all projects. DSRIP incentive funding for each project will be allocated based on the percentage of points each project received.
The Reeves County Hospital District-Pecos Valley Rural Health Clinic Patient Experience Improvement Initiative received a ranking of 6 points out of the 24 possible points available. As a result for each year under the waiver 25% (6/24 =.25 or 25%) of Category 3 funds available will be allocated to the Patient Experience Project. Furthermore, for each year of the Waiver, funds will be equally divided by each Process Milestone or Outcome Improvement Target in that given year.

112684904.3.7	*OD -6, 3.IT-6.1*	*Patient Satisfaction*	
Reeves County Hospital District		*112684904*	
Related Category 2 Projects:	*Unique Category 2 Project Identifier: 112684904.2.3*		
Starting Point/Baseline:	*To be developed in Year 2*		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Process Milestone 1: **[P-2]** Establish baseline rates **Data Source:** Survey Results **Process Milestone 1 Estimated Incentive Payment*:* $22,116**	**Process Milestone 2 [P-5] :** Disseminate finding, including lessons learned and best practices, to stakeholders **Data Source:** Submission of findings **Process Milestone 2 Estimated Incentive Payment: $38,453**	**Outcome Improvement Target 1 [IT -6.1]** Percent improvement of 5% over baseline of patient satisfaction scores for a subset of measures that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey will be used to establish if patients: (1) are getting timely care, appointments, and information; (2) how well their doctors communicate; (4) patient's involvement in shared decision making, and (Only those areas identified in Year 2 finding will be targeted for improvement. **A. Numerator:** Percent improvement in targeted patient satisfaction domain **B. Data Source:** Patient Survey **Outcome Improvement Target 1 Estimated Incentive Payment*:* $54,848**	**Outcome Improvement Target 2** [**IT -6.1]** Percent improvement of 10% over baseline of patient satisfaction scores for a subset of measures that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey will be used to establish if patients:(1) are getting timely care, appointments, and information; (2) how well their doctors communicate; (4) patient's involvement in shared decision making, and (Only those areas identified in Year 2 finding will be targeted for improvement. **A. Numerator:** Percent improvement in targeted patient satisfaction domain **B. Data Source:** Patient Survey **Outcome Improvement Target 2 Estimated Incentive Payment*:* $98,369**
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome	Year 4 Estimated Outcome	Year 5 Estimated Outcome Amount:

(add incentive payments amounts from each milestone/outcome improvement target): $22,116	Amount: $38,453	Amount: $54,848	$98,369
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $213,786			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD-6, Patient Satisfaction IT-6.1
Unique Identifier: 130725806.3.1
Performing Provider: West Texas Centers/130825806

Outcome Measure Description:

West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This expectation was increased to 40% in DY 5. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

Our Center will additionally be working with other Community Centers in learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

All West Texas Center counties in RHP 14 are designated Health Professional Shortage Areas (HPSAs), with a very rural population. The closest major medical center or any behavioral health care other than West Texas Centers is thirty to seventy miles. West Texas Centers is the only provider of behavioral health services in most of these counties. Without telemedicine it would not be possible to provide the psychiatric services which are currently being provided. Current capacity however; does not meet the demands of the rural area. This expansion of telemedicine will enable West Texas Centers to increase access to services via the increase in capacity achieved through further broadband connectivity and acquisition of newer, more advanced telecommunication connections and software. All process measures were chosen to identify baseline data, obtain public feedback and provide time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve

maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

Outcome Measure Valuation:

Outcome evaluation consideration included West Texas Center's current telemedicine system costs and estimated costs of achieving all project goals. Additionally, consideration was given to current crisis response times in the project Counties, county patient satisfaction with current telemedicine technology/services, availability of other behavioral health providers and length of waiting time for psychiatric services in the project locations. Provider has adopted the regional valuation set forth by RHP 14. Based on this methodology, 10 percent of the total valuation in DY 3 is associated with establishing capability to file and collect the necessary reports. 10 percent of the provider allocation is associated with DY 4, with 20% for DY 5, across the applicable domains. Additional sources for valuation consideration used included economic evaluation models and extensive literature reviews which were conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.

Improvement targets were selected to insure improvement in patient satisfaction related to timely care, appointments and information. Selected improvement measures of 25% and 40% respectively in DY 4 and % indicate a high degree of confidence patients will see significant improvements in their overall access to behavioral health care.

130725806.3.2	***IT-6.1***	**IT-6.1 Percent Improvement over baseline of patient satisfaction scores**	
West Texas Centers			
Related Category 1 or 2 Projects	***130725806.2.1***		
Starting Point/Baseline	**Satisfaction Surveys conducted DY 3:Measurement will be based upon DY3 satisfaction survey**		
Year 2 (10/1/2012-9/30/2013)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15-9/30/16)
Process Milestone P-1(Cat 3, pg 363, P01) Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project planning and implementation documentation demonstrates plan, do study, act quality improvement cycles. Process Milestone P-1:Estimated Incentive Payment*:* $0.00	Process Milestone P-3(Cat 3, pg. Pg, 363, P-3) Develop and test systems to capture baseline information, select consumer survey documents, conduct baseline patient satisfaction survey to achieve baseline and begin new provider education on systems. Data Source: Provider feedback, customer satisfaction surveys and computer based training documents. Process Milestone P-3: Estimated Incentive Payment :$62,425.00	Outcome Improvement Target 1 Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Improvement Target: 25% improvement over baseline of patient satisfaction scores related to the standalone measure: patients are getting timely care, appointments, and information. Data Source/baseline: DY 3 Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $66,780.00	Outcome Improvement Target 2 Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Improvement Target: 40% improvement over baseline of patient satisfaction scores related to the standalone measure: patients are getting timely care, appointments, and information. Data Source/baseline: DY 3 Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $145,174.00

Year 2 Estimated Outcome Amount: $0.00	Year 3 Estimated Outcome Amount: $62,245	Year 4 Estimated Outcome Amount: $66,780	Year 5 Estimated Outcome Amount: $145,174
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $274,379			

Identifying Outcome Measure and Provider Information:
Outcome Measure: OD-6: Patient Satisfaction; IT-6.1
Unique Identifier: 130725806.3.2
Performing Provider: West Texas Centers/ 130725806

Outcome Measure Description:

West Texas Centers has selected process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures.

West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with improvement target IT-6-1: Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the improvement targets established were 25% improvement over baseline in DY 4. This expectation was increased to 40% in DY 5. This improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

Our Center will additionally be working with other Community Centers in learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

This project represents a new initiative for West Texas Centers as well as the RHP. Howard County currently has providers in separate facilities with only limited interaction. Process measures were selected to define a baseline for quality improvement targets. As West Texas Centers is not currently conducting integrated service delivery with primary care, data systems, consumer satisfaction instruments and other methods of data collection for this project will have to be reviewed, revised or developed during DY 2 and 3 in order to identify and achieve improvement targets for DY 4 and 5. Process milestones were selected to facilitate identifying appropriate data sources for surveying and gathering patient satisfaction data. Since West Texas Centers does not currently operate a primary and behavioral health integrated service site, all process milestones were chosen in consideration of the lack of accurate reports and resources currently available to measure and monitor potential improvement targets for an integration project.

Outcome Measure Valuation:

West Texas Centers considered several factors in valuing this project, including, reduction in cost associated with emergency room visits and hospitalizations for primary care and behavioral health care. Research supports and West Texas Center expects this project will improve the physical health of the behavioral health consumer through a higher degree of access to primary care, decreased emergency room visits and hospitalizations. An additional valuation factor used for this project is the research associated with identifying a monetary value for a collaborative primary/behavioral health intervention which is measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Substantive research supports the quality of life improvement of integrated services, particularly for the behavioral health consumer. Improvement measures were selected to effectively determine if patients in the new integrated care environment are receiving services more holistically focused to achieve easier access to both behavioral healthcare and primary care, but also to insure services are improving "whole body" outcomes. Desired outcomes include both improved patient experience and the cost effectiveness of integrated treatment. Additional sources for valuation consideration used included economic evaluation models and extensive literature reviews which were conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.

130725806.3.2	***IT-6.1***	**IT-6.1 Percent Improvement over baseline of patient satisfaction scores**	
West Texas Centers			
Related Category 1 or 2 Projects	***130725806.2.1***		
Starting Point/Baseline	***To be established in DY 2***		
Year 2 (10/1/2012-9/30/2013)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15-9/30/16)
Process Milestone P-1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project planning and implementation documentation demonstrates plan, do study, act quality improvement cycles. Process Milestone 1 Estimated Incentive Payment*:* $0.00	Process Milestone P-3(Cat 3, pg. Pg, 363, P-3) Develop and test systems to capture baseline information, select consumer survey documents, conduct baseline patient satisfaction survey to achieve baseline and begin new provider education on systems. Data Source: Provider feedback, customer satisfaction surveys and computer based training documents. Process Milestone P-3 Estimated Incentive Payment*:* $88,516	Outcome Improvement Target 1: Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Improvement Target: 25% improvement over baseline of patient satisfaction scores related to the standalone measure: patients are getting timely care, appointments, and information. Data Source/baseline: DY 3 Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $94,692	Outcome Improvement Target 2: Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Improvement Target: 40% improvement over baseline of patient satisfaction scores related to the standalone measure: patients are getting timely care, appointments, and information. Data Source/baseline: DY 3 Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $205,851

Year 2 Estimated Outcome Amount: $0.00	Year 3 Estimated Outcome Amount: $88,516	Year 4 Estimated Outcome Amount: $94,692	Year 5 Estimated Outcome Amount: $205,851.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $389,059			

F. Category 4: Population-Focused Improvements (Hospitals only)

Performing Provider: Medical Center Health System [TPI: 135235306]
Unique Category 4 Domain Identifiers:

135235306.4.1	Capability of reporting on data items DY3-5
135235306.4.2	Potentially Preventable Admissions
135235306.4.3	Potentially Preventable Readmissions – 30 days
135235306.4.4	Potentially Preventable Complications
135235306.4.5	Patient Centered Healthcare
135235306.4.6	Emergency Department
Domain 6	Not Reporting

Domain Descriptions:

- **Domain 1: Potentially Preventable Admissions:**

  Increase patient options: By increasing access through infrastructure development (135235306.1.1, 1.2, 1.3), increasing overall physician population, expanding the screening and treatment options in conjunction with the local Health Department (135235306.2.5), and increasing the amount of community resources available (135235306.2.1,2.2,2.7) we hope to lessen the number of our potentially preventable admissions (in all areas). MCHS believes that admissions occur due to a failure to recognize and treat disease in the outpatient setting. There are numerous opportunities to access patients in non-traditional methods, and we feel that our projects help us do that. We hope in particular to impact significantly diabetic admissions, because of our focus on diabetes not only in our Diabetes project (135235306.2.5), but also through the expansion of primary care sites that will treat the disease.

  Increase patient's knowledge and comfort level with the System: Health Literacy and education is a core component of each MCHS project. We are crafting the plan to utilize every opportunity we have to get patients the information they need to make informed choices about their health and wellness. Health Literacy in schools (135235306.1.2, 135235306.2.5) will help us ensure that the next generation has more access to health information than the previous ones did. Asthma education, Nutrition, and diabetes education will be factored into the school programs. Community outreach through the different navigation programs (135235306.2.1, 2.2, and 2.7) will help create awareness about specific disease states. With a focus on prevention and detection, our navigators will help reduce admissions.

  Additionally healthcare literature tells us that Palliative care (135235306.2.6) is also associated with fewer hospitalizations and fewer ICU hospital days because of medically

appropriate goal setting and matching resource use to the goal of care set by the patient and the palliative care team.

- **Domain 2: Potentially Preventable Readmissions:**

  Several of MCHS's Category 1 and 2 projects look at reducing readmissions. First, through identification and disease management, Medical Center in conjunction with the Ector County Health Department, will be able to screen and educate Odessans and will then be able to identify patients in need of a medical home to control either diabetes or pre-diabetes 135235306.2.5).

  Adding primary care access points and specialty providers will allow patients to seek and obtain timely medical care (135235306.1.1, 1.2, and 1.3) lessening the possibility of readmissions due to lack of appropriate follow up outpatient care. This in turn will affect all-cause readmissions moving forward.

  Additionally, we believe achievement of a lower 30-Day CHF readmission rate can be achieved through the implementation of our CHF Project (135235306.2.1). Our Care Transitions (135235306.2.2) project will positive affect our 3-day All Cause readmission rate through the implementation of robust case management and an innovative community navigator role.

- **Domain 3: Potentially Preventable Complications:**

  MCHS has two projects specifically geared to prevent complications. Our Sepsis project (135235306.2.3) will focus on expanding resources and education to help detect and treat sepsis before it becomes severe sepsis or septic shock. The mobility team project (135235306.2.4) is designed to not only reduce Hospital acquired pressure ulcers but improve the patient's experience in the hospital. The teams utilize nursing students which allows them to gain practical experience and understand the importance of turning patients.

- **Domain 4: Patient Centered Healthcare:**

  For the past five year, MCHS leadership has made improvement of our inpatient satisfaction scores (HCAHPS) an organizational priority. We have seen and expect to continue seeing improvement in all HCAHPS areas. MCHS monitors HCAHPS scores monthly and reports them not only to the various Hospital Boards and sub-committees but to all employees—both in composite score form and broken down by unit. Deficiencies are carefully reviewed and action plans developed with follow-up review. This past year, our general employee orientation program section on patient satisfaction was rewritten and expanded to include more information on the impact of customer

service on patient satisfaction including actual footage from focus groups of former patients. Service excellence award programs were developed to take directly to the individual departments, therefore encouraging the staff to take an active role in the patient experience. MCHS will continue to look for, evaluate and implement those new, evidence-based practices that will enhance our patient centered care. The interpretation project (135235306.1.4) will provide much needed support to the staff and the patients, thereby increasing scores through better communication.

- **Domain 5: Emergency Department Throughput:**

  Emergency Department throughput has been a CMS quality focus for a number of years and of great interest to MCHS. In the past several years, MCHS's efforts in this area have shown incremental success. RHP's Community Needs Assessment mentions the inappropriate use of the ED for primary care. The virulence of this year's flu season and the tremendous growth in the area's population has only exacerbated this problem. MCHS has taken steps to move the volume from the ED to more appropriate sites of care through the opening of two urgent care clinics. Through the waiver we will further enhance this ability (135235306.1.1 and 1.2) by offering urgent care services at more sites and increased access to a primary physician.

- **Domain Valuation:**

Medical Center Health System will not be participating in Domain 6 of Category 4 so funds allotted to Category 4 are limited to 10% of the total DSRIP funds Midland receives. When valuing each of the Category 4 reporting domains, we divided the 10% of funds allotted to Category 4 equally among the reporting requirements for that year. This reporting seeks to demonstrate a reduction in potentially preventable admissions, readmissions, and complications, as well as improvement in patient satisfaction and emergency department throughput. Improvements in these domains will result in better health outcomes for patients. The development and implementation of this reporting will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run.

Category 4: Population-Focused Measures ***Medical Center Health System/ 135235306***				
Year 2 (10/1/2012 – 9/30/2013)		**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: 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.		
$776,101		$359,841		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$359,841	$384,946	$418,420
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$359,841	$384,946	$418,420
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$384,946	$418,420
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$359,841	$384,946	$418,420
Domain 5: Emergency Department				

Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$359,841	$384,946	$418,420
OPTIONAL Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive		$0	$0	$0

Amount				
Grand Total Payments Across Category 4	$776,101	$1,799,205	$1,924,731	$2,092,099

Performing Provider: Midland Memorial Hospital [TPI: 136143806]
Unique Category 4 Domain Identifiers:

- **Domain Descriptions:**

  We anticipate that our work in Categories 1-3 will show impact in Domains 1-5. All of our projects are focused on patient education and inclusiveness. We want not only to make health care accessible but to better educate our various publics, particularly those among our disparate groups, about their own role in assisting us to better their health. We believe that by working to make our community members, partners with us in their healthcare, all these efforts will lower the number of potential preventable admissions and readmissions in our area. We also expect to reduce the possible number of preventable complications our patients have faced particularly in the area of diabetes and prenatal care as well as lower throughput time in the Emergency Department because of reduced (1) non-emergent utilization and (2) re-admissions via the ED.

- **Domain 1: Potentially Preventable Admissions:**

  Increase patient options: By recruiting more physicians (136143806.1.1), expanding the screening and treatment options at the local Health Department (136143806.2.2), increasing the treatment options at the local FQHC located in a medically underserved area in our City (136143806.1.3), making medical advice available via their [patients'] phones (16143806.1.2), and adding primary care to the EMS structure—taking primary care to the streets (136143806.2.1), we hope to lessen the number of our potentially preventable admissions (in all areas). We believe we can impact this Domain by making accessible primary care more available to our community so that medical issues are addressed in a timely fashion before they become critical and require a hospital stay. We hope in particular to impact significantly diabetic admissions, because of our focus on diabetes in several of our projects but particularly our work with the Health Department and MCHS (136143806.2.2).

  Increase patient's knowledge and comfort level with the System: We also believe that we can impact all areas of Domain 1 if we augment a patient's knowledge and comfort level with our community's healthcare system by educating them concerning their options for seeking care (136143806.2.4, 136143806.1.2, 136143806.2.1), what their health issues are through free or income-adjusted screenings/care in their neighborhoods (136143806.2.4 & 136143806.1.3, 136143806.2.2) and what complications are possible through lack of action (136143806.2.4). To be effective, we must communicate this information in their language (136143806.2.4, 136143806.1.4). If we successfully increase a patient's knowledge and comfort level with our Community's healthcare system then we will see lower admission rates particularly for diabetes and hypertension.

Additionally healthcare literature tells us that Palliative care (136143806.2.3) is also associated with fewer hospitalizations and fewer ICU hospital days because of medically appropriate goal setting and matching resource use to the goal of care set by the patient and the palliative care team.

- **Domain 2: Potentially Preventable Readmissions:**

  Several of Midland Memorial's Category 1 and 2 projects look at reducing readmissions. First, through identification and disease management, MMH in conjunction with MCHS and MHD, will be able to track and manage a patient's condition through a disease registry to assist them in avoidance of being readmitted for diabetic issues (136143806.2.2).

  Adding primary care and specialty providers will allow patients to seek and obtain timely medical care (136143806.1.1 & 136143806.1.5) lessening the possibility of readmissions due to lack of appropriate follow up outpatient care.

  Additionally, we believe achievement of a lower all-cause 30-day readmission rate (136143806.1.4) will result when our Spanish speaking population better understands discharge and medication instructions upon release from our Hospital. This enhanced comprehension will be facilitated by making sure we have this conversation with them in their primary language.

- **Domain 3: Potentially Preventable Complications:**

  While a variety of related quality improvement efforts are already in place at MMH, none of our nine (9) DSRIP projects specifically focuses on in-hospital PPC's.

- **Domain 4: Patient Centered Healthcare:**

  For the past two years, MMH leadership has made improvement of our inpatient satisfaction scores (HCAHPS) an organizational priority. We have seen and expect to continue seeing improvement in all HCAHPS areas. MMH monitors HCAHPS scores monthly and reports them not only to the various Hospital Boards and sub-committees but to all employees—both in composite score form and broken down by unit. Deficiencies are carefully reviewed and action plans developed with follow-up review. This past year, our general employee orientation program section on patient satisfaction was rewritten and expanded to include more information on the impact of customer service on patient satisfaction including actual footage from focus groups of former patients. A service excellence class was developed to take directly to the individual departments. MMH will continue to look for, evaluate and implement those new, evidence-based practices that will enhance our patient centered care.

Lastly, evidence suggests (see Project 136143806.2.3 – Use of Palliative Care Programs) that the implementation of a palliative care program (Smith and Cassel, 2009) resulted in higher quality, greater satisfaction and lower costs due to control over the clinical care of the patient.

We are currently revising our Medication Reconciliation procedures and how this information is captured in our EHR in light of DSRIP reporting requirements to catalog a patient's medications as required thereby ensuring that patients and family members clearly understand what medication the patient should currently be taking and why as well as what past medication have been discontinued and why. Hopefully, this will lessen post discharge ED visits and readmissions due to inadequate understanding of proper medication usage.

- **Domain 5: Emergency Department Throughput:**

Emergency Department throughput has been a CMS quality focus for a number of years and of great interest to MMH. In the past several years, MMH's efforts in this area have met with minimum success. RHP's Community Needs Assessment mentions the inappropriate use of the ED for primary care. The virulence of this year's flu season and the tremendous growth in the area's population have only exacerbated this problem. In an effort to improve ED throughput, MMH has taken a number of internal steps in the past month including (1) opening a clinical decision unit to offload potential admissions and free up ED rooms for new patients, (2) increasing the number of triage nurses to two so that patients can be processed quicker, (3) increasing provider coverage from 1 to 2 physicians/20 hours a day as well as several mid-levels, (4) expanding the actual capacity of the ED (effective June, 2013) while keeping the same clinical (staff to room) ratios. We will continue to look for evidence-based practices to enhance this process.

In addition to these changes, several of our DSRIP projects aimed at increasing primary care options within the community (136143806.1.1 & 136143806.1.3), better disease management (136143806.2.2 & 136143806.2.4) and increased efforts at patient navigation (136143806.1.2 & 13614380632.1), will impact ED congestion by diverting non-emergent patients for care to more appropriate, cost effective environments. Lastly, the increase of interpretation services within our facility, including in the ED (136143806.1.4) will remove delays in the ED caused by need to communicate via another language.

- **Domain Valuation:**

Midland Memorial Hospital will not be participating in Domain 6 of Category 4 so funds allotted to Category 4 are limited to 10% of the total DSRIP funds Midland receives.

When valuing each of the Category 4 reporting domains, Midland divided the 10% of funds allotted to Category 4 equally among the reporting requirements for that year. This reporting seeks to demonstrate a reduction in potentially preventable admissions, readmissions, and complications, as well as improvement in patient satisfaction and emergency department throughput. Improvements in these domains will result in better health outcomes for patients. The development and implementation of this reporting will take significant resources (time, money, training, maintenance), though it will ultimately yield high benefits for those at risk and save money in the long run.

Category 4: Population-Focused Measures *Midland Memorial Hospital-TPI: 136143806*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$564,546	$261,753		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		Period 2	Period 2	Period 2
Domain 1 - Estimated Maximum Incentive Amount		$261,753	$280,014	$304,363
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		Period 2	Period 2	Period 2
Domain 2 - Estimated Maximum Incentive Amount		$261,753	$280,015	$304,363
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			Period 2	Period 2
Domain 3 - Estimated Maximum Incentive Amount			$280,015	$304,364
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		Period 2	Period 2	Period 2
Medication Management				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		Period 2	Period 2	Period 2
Domain 4 - Estimated Maximum Incentive Amount		$261,753	$280,015	$304,364

Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		Period 2	Period 2	Period 2
Domain 5 - Estimated Maximum Incentive Amount		$261,753	$280,015	$304,364

<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures – Opt not to participate in this Domain				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				

Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	**$564,546**	**$1,308,764**	**$1,400,073**	**$1,521,817**

Performing Provider: Odessa Regional Medical Center [TPI: 112711003]

Domain Descriptions: ORMC has developed a comprehensive set of projects to improve access, lower costs, and increase satisfaction for the population of RHP 14. The projects within categories 1, 2, and 3 relate to at least one of the domains in category 4 and are as follows:

Domain 1: Potentially Preventable Admissions

Relationship with other Categories
ORMC has addressed this domain through its expansion of primary care, development of chronic care management, and increasing its preventive screening capabilities. ORMC believes that through an expanded outpatient presence, it can proactively manage the population's health in a more effective environment and prevent potential admissions.

The community needs assessment clearly documents a lack of primary care capacity within RHP 14. Expansion of existing clinic hours along with the recruitment and establishment of new primary care providers will increase access and provide care to an expanded patient base. The mobile program will expand primary care services to a population usually outside of ORMC's service area in hopes of increasing access to, and beyond Odessa.

Expanding chronic care management models through diabetes and CHF clinics will help establish a disease management program for patients impacted by both. The goal of this will be to proactively manage these conditions to avoid hospitalizations that would otherwise occur. These programs will assist the patient in monitoring these chronic conditions through evidence based protocols, and follow ups for compliance.

Development of preventive screening measures will also assist in identifying high risk patients so conditions can be managed sooner, mitigating potential factors that could lead to hospital admission. ORMC has identified specific population groups within the community needs assessment, and has chosen screenings recommended by the U.S. Preventive Services Task Force.

Expected Improvements:
Admissions for the following categories are expected to decrease in DY's 2-5 for: Congestive Heart Failure Admission rate, Diabetes Admission rates, and Hypertension Admission. Increases are expected to be seen in DY's 2-5 for: bacterial pneumonia immunization and influenza immunizations.

Domain 2: Potentially Preventable Readmissions

Relationship with other Categories
Several of the programs within ORMC's category 1 and 2 also look at reducing 30 day readmissions. Through identification and disease management, ORMC will be able to track and manage a patient's condition to keep them from being readmitted. A patient registry will be

developed to better assist patients identified by ORMC whom are more likely to receive fragmented care. Many of these patients will be identified through admission into the hospital or through over utilization of our ED, assisting with identification of which patients are truly in need. Patients will be directed to various options associated with their conditions, several of which have been developed through DSRIP.

All category one and two projects in development have been chosen due to the prevalence of certain conditions within the RHP. The Congestive Heart Failure clinic will specifically look at readmissions for those with that diagnosis in order to show improvements for patients with that condition. A diabetes program will also look at better management of glucose levels through development of an outpatient program. Both clinics will serve a patient base from patients whom have been admitted, identified, and then referred by our patient navigator program.

Expected Improvements:
Readmissions for the following categories are expected to decrease in DY's 4-5: Congestive Heart Failure, diabetes, as well as the all cause 30-day readmission. DY's 2-3 will be used to develop the infrastructure necessary for the program and to ensure ORMC has the capabilities to track and manage this data.

Domain 3: Potentially Preventable Complications

Relationship with other Categories
Out of the 64 potentially preventable complications, ORMC has already begun to focus on reducing all. In relationship with DSRIP, PPC#'s 1, 10, 35 will be directly impacted due to procedural improvements implemented.

ORMC already has neurology capabilities within its own facilities, and hopes to offer this throughout the region via telemedicine. Timely identification and treatment of a stroke is critical for positive outcomes, and will assist in reducing potentially preventable complications. Congestive Heart Failure is another condition that needs to be managed properly if complications are to be avoided. Through the establishment of a CHF clinic, ORMC will be better able to care for CHF patients in both the inpatient and outpatient setting. Better management will lead to fewer complications normally associated with CHF.

Implementation of the Sepsis Resuscitation and Management Bundles will decrease the number of Sepsis Mortalities and complications at ORMC. The Institute of Healthcare Improvement and Surviving Sepsis Campaign have both endorsed the bundles as an organized process of evidenced based practices that guarantees early recognition and treatment. Through the establishment of both sepsis bundles, both complications and mortalities will be avoided.

Expected Improvements:

Decreases in complications will be evidenced in DY2-5 for the following complications: Stroke and Intracranial Hemorrhage, Congestive Heart Failure, and Septicemia and Severe Infections. The previously mentioned complications will be directly related to projects within the DSRIP menus. With that said, ORMC has been at the forefront for improving outcomes and decreasing complications, and will continue to develop processes to decrease complications within all 64 categories.

Domain 4: Patient Centered Healthcare

Relationship with other Categories

Both aspects of Patient centered healthcare continue to be reviewed and assessed in order to make improvements in both. Patient satisfaction scores are reported through HCAHPS and continue to be a focus, as processes are developed to increase the patient experience at ORMC. Medication reconciliations also look at being improved upon through the adoption of "meaningful use" via our Electronic Health Record.

HCAHPS continues to be a focal point for ORMC and has dedicated a department to improving the patient experience. HCAHPS reporting domains are currently tracked and reported on a monthly basis to several of the medical staff and board meetings. DSRIP projects are expected to maintain and assist in improving the standard ORMC has already set regarding patient satisfaction.

ORMC has also been at the forefront of Electronic Health Record adoption. This adoption continues to grow as it continues in its goal for full utilization of our EHR. Medication reconciliations are a big part in the push, as we plan to offer this electronically at the time of discharge.

Expected Improvements:

ORMC plans to continue to develop its emphasis on patient satisfaction, and believes that it will continue to remain strong within the HCAHPS domains. While each of the categories within DSRIP will not directly impact HCAHPS, patients will be able to access a wider array of services which will in turn increase patient satisfaction. Adoption of our EHR will also increase ORMC's capabilities to offer medication reconciliations at discharge. Improvement in offering medication reconciliations should begin in late DY3 and increase till DY5.

Domain 5: Emergency Department

Relationship with other Categories

Emergency departments across the state have become overcrowded, resulting in long wait times, rushed treatment, and potentially poor outcomes. Through the development of programs and processes within the DSRIP categories, ORMC hopes to reduce this burden through expansion of primary care, proactive disease management programs, and better patient navigation. Each will assist in alleviating Emergency room congestion and a decrease in admit decision time to time of departure from the Emergency Room.

Expanding primary care will offer more care to patients who might not have access, and result in less trips to the ED. If conditions are identified and managed, patients will be less likely to seek treatment through the more expensive emergency room. Chronic conditions such as diabetes and CHF can also lead to ED visits if not properly managed. Through chronic conditions management programs, ORMC will be able to assist in proper management of these conditions in hopes of avoiding complications.

Expected Improvements:
ORMC has developed programs to keep patients from coming into the ED in hopes of managing their care in a more cost effective environment. This will be displayed in an increased capability to serve ED patients in a timelier manner, therefore reducing time from admit decision time to time of departure from the Emergency Room. Demonstration Years 4 and 5 should see the most dramatic decrease in time, due to completion of project infrastructure for the various categories.

Infrastructure Development

Currently ORMC is in development of dashboards to support the reporting elements within category 4. Current systems are being analyzed and tested to develop what its current capabilities are, along with confirming which metrics are currently being monitored. A needs assessment will be developed to document and communicate what tools and systems still need to be developed with current EHR vendor. Development of interfaces between our EHR and registration systems will also be looked at extensively. The build and implementation of an interface will be a timely, but necessary process to ensure data is flowing smoothly between systems.

Once capabilities are identified and confirmed, ORMC will need to develop processes to ensure correct documentation and data are captured. Accurate data capture will be essential in monitoring this data to ensure all reporting tools are accurate and can be monitored on a consistent basis.

Valuation

In valuing this project, ORMC looked at the overall goal of category 4, building the capacity for reporting on a comprehensive menu set of population health metrics. ORMC also took into account the infrastructure requirements to build upon current capabilities. Due to no improvement requirements set, ORMC felt it would be best to keep all reporting amounts equal amongst domains, with a slight increase for implementation in DY's 3 through 5.

Category 4: Population-Focused Measures **[Odessa Regional Medical Center, 112711003]**				
	Year 2 **(10/1/2012 – 9/30/2013)**	**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	$500,000	$230,000		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$230,000	$243,800	$263,304
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$230,000	$243,800	$263,304
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$243,800	$263,304
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				

Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$230,000	$243,800	$263,304
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$230,000	$243,800	$263,304
Grand Total Payments Across Category 4	$500,000	$1,150,000	$1,219,000	$1,316,520

- ***Category 4: Population-Focused Improvements***

  For each hospital Performing Provider, the following information should be included:
  Winkler County Memorial Hospital: TPI# 094204701

Domain Descriptions:

- RD-1. Potentially Preventable Admissions
- RD-2. 30-day readmissions
- RD-3. Potentially Preventable Complications (PPCs)
- RD-4. Patient-centered Healthcare
- RD-5. Emergency Department

Note:
Winkler County Memorial Hospital will not report on RD-6, Initial Core Set of Health Care Quality Measures. WCMH does not provide these services in our rural hospital.

Domain 1: Potentially Preventable Admissions (PPAs)
WCMH Implementation of a Patient-Centered Medical Home (PCMH) will improve care coordination and prevent admissions with more emphasis given in the outpatient setting. The additional clinic space will allow providers to increase their ability to plan and monitor patient care in an effort to diagnose disease and infection early enough to provide treatment in the outpatient setting without hospitalization.

Domain 2: Potentially Preventable Readmissions
After hospitalizations the care team organized within WCMH and RHC will follow up with patients in communicating with primary care providers and specialists alike to determine follow-up and preventative measures of clinical care to prevent relapse or deterioration. While WCMH aims to put patients at the center of their own health care experiences as an engaged decision maker, it will ultimately serve in plotting a course toward improved patient outcomes. With the increase in patient centered space in the clinic the providers can concentrate patients care and education in a private and comfortable environment.

Domain 3: Potentially Preventable Complications (PPC)
Communication with patients who require hospitalization for serious illness or injury from the providers responsible for their care will be paramount. Allowing a provider to follow their patients and remain actively involved in their treatment while receiving inpatient care reduces the coordination issue and alleviates many patient centered concerns for follow up or post-admission care plans.

Domain 4: Patient Centered Healthcare
A focus on patient preferences, WCMH will play a key role in adopting similar principles within the hospital setting. Effective communication is fundamental in patient centered care. As the vast majority of all providers working in the inpatient setting at Winkler County Memorial Hospital will also be seeing the same patients, there will be crossover benefits. This situation provides an added communication channel to ensure that patient preferences are incorporated

into hospital based decision making. Informed or shared decision making—in which patients, families, and clinicians work together to balance scientific evidence and patient preferences to make optimal medical decisions with the patient— is just as important a part of a highly functional hospital as a primary care clinic.

Domain 5: Emergency Department

WCMH seeks to provide the right care at the right time and in the right setting, the hope is that over time, patients in Winkler County see their overall health improve and ultimately rely less on costly emergency department visits. With the space renovation, the clinic will be able to provide more open appointment slots, or walk-in availability, so that non-emergent care needed by patients presenting in the emergency department can be directly referred to a same-day visit to their provider.

Note:

Winkler County Memorial Hospital will not report on RD-6, Initial Core Set of Health Care Quality Measures. WCMH does not provide these services in our rural hospital.

Domain Valuation: Preferred Hospital has adopted the regional valuation set forth by RHP 14. Based on this methodology, 5 percent of the total valuation in DY 2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

Category 4: Population-Focused Measures Winkler County Memorial Hospital				
	Year 2 (10/1/2012 – 9/30/2013)	**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.		
Est. Max Incentive Amount	$5,135	$0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1		1	1	1
Domain 1 – Est. Max Incentive Amount		$2,976	$2,547	$2,768
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 2		2	2	2
Domain 2 – Est. Max Incentive Amount		$2,976	$2,547	$2,768
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1			1	1
Domain 3 – Est. Max Incentive Amount			$2,547	$2,768
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 2				
Medication Management				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1		1	1	1
Domain 4 – Est. Max Incentive Amount		$2,976	$2,547	$2,768
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 2		2	2	2
Domain 5 – Est. Max Incentive Amount		$2,976	$2,547	$2,768

Grand Total Payments Across Category 4	**$ 5,135**	**$ 11,904**	**$ 12,735**	**$ 13,840**

Provider Information:
Culberson Hospital
TPI - 176354201

Domain Descriptions:
Domain 1: Potentially Preventable Admissions (PPAs)
Implementation of a Patient-Centered Medical Home (PCMH) will improve care coordination and prevent admissions due to dropped handoffs between various clinical provider teams. The PCMH model will allow providers to seamlessly plan and monitor patient care in an effort to diagnose disease and infection early enough to provide treatment without hospitalization.

Domain 2: Potentially Preventable Readmissions
After hospitalizations care teams organized within the PCMH will follow up with patients serving as their navigators in communicating with primary care providers and specialists alike to determine follow-up and preventative measures of clinical care to prevent relapse or deterioration. While the PCMH aims to put patients at the center of their own health care experiences as an engaged decision maker, it will ultimately serve in plotting a course toward improved patient outcomes.

Domain 3: Potentially Preventable Complications (PPC)
Patients who require hospitalization for serious illness or injury have a particularly strong need for communication and coordination among the providers responsible for their care. Many experts believe that the synchronization of care can be worst in this stage. Allowing a provider to follow their patients and remain actively involved in their treatment while receiving inpatient care reduces the coordination issue. Avoiding the use of hospitalists and managing inpatient care with the same providers anchoring the PCMH will reduce complications or worsening of conditions.

Domain 4: Patient Centered Healthcare
A focus on patient preferences, within the PCMH will play a key role in adopting similar principles within the hospital setting. Effective communication is fundamental in patient centered care. As the vast majority of all providers working in the inpatient setting at Culberson Hospital will also be seeing the same patients in the newly established PCMH, there will be crossover benefits. This situation provides an added communication channel to ensure that patient preferences are incorporated into hospital based decision making. Informed or shared decision making—in which patients, families, and clinicians work together to balance scientific evidence and patient preferences to make optimal medical decisions with the patient— is just as important a part of a highly functional hospital as a primary care clinic.

Domain 5: Emergency Department
As the PCMH seeks to provide the right care at the right time and in the right setting, the hope is that over time, patients in Culberson County see their overall health improve and ultimately rely less on costly emergency department visits. The PCMH model will allow physicians to plan and monitor all their care in an effort to diagnose illnesses early enough to provide treatment

without a trip to the emergency department, thereby, resulting in a decreased non emergent visits.

Valuation

Culberson Hospital has adopted a valuation standard based on the following methodology:

- 5 percent of the total valuation in DY 2 is associated with establishing capability to file and collect the necessary reports.
- 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains.

Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

Outcome Measure Description:

Year 2: Culberson Hospital will spend the initial year in planning for the transition of the current primary care clinic to the Patient-Centered Medical Home Model. This process will include a gap analysis and feasibility study to determine procedural steps and special needs of the program moving forward.

Category 4: Population-Focused Measures *Culberson Hospital* 176354201				
	Year 2	**Year 3**	**Year 4**	**Year 5**
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	$7,171	$0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period:		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$4,156	$3,556	$3,866
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period:		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$4,156	$3,556	$3,866
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period:			2	2
Domain 3 - Estimated Maximum Incentive Amount			$3,556	$3,866
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period:			2	2
Medication Management				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015

Planned Reporting Period:			2	2
Domain 4 - Estimated Maximum Incentive Amount		$4,156	$3,556	$3,866
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period:		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$4,156	$3,556	$3,866
Grand Total Payments Across Category 4	$7,171	$16,624	$17,780	$19,330

Section VI. RHP Participation Certifications

Each RHP participant that will be providing State match or receiving pool payments must sign the following certification.

By my signature below, I certify the following facts:

- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document;
- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization
	William Webster	*Medical Center Health System*
	Dianne Yeager	*Crane Memorial Hospital*
	Russell Meyers	*Midland Memorial Hospital*
	Russell Tippin	*Permian Regional Medical Center*
	John Irby	*Scenic Mountain Medical Center*
	Rance Ramsey	*Martin County Hospital District*
	Lorenzo Serrano	*Reeves County Hospital District*
	Jared Chanski	*Culberson Hospital*
	Christopher Mendoza	*Odessa Regional Medical Center*
	Kandy Stewart	*Texas Tech University Health Sciences Center-Permian Basin*
	Larry Carroll	*Permian Basin Community Centers*
	Gino Solla	*Ector County Health Department*
	Shelley Smith	*West Texas Centers*
	Michael Ellis	*Big Bend Regional Medical Center*
	Celestino Garcia	*Midland Health Department*

	Jodie Gulihur	*McCamey Hospital District*
	William Ernst	*Winkler County Memorial Hospital*

Section VII. Addendums

	DSRIP Projects – Considered but Not Developed
	Midland Memorial
1	TTUHSC (Lubbock) General Surgery residency rotation
2	ICNET – enhancing improvement capacity through technology
3	Patient surveying & subsequent process improvement (HCAHPS)
4	Dietetic Internship Program
5	Expansion of our current Urgent Care Center via relocation
6	Develop of an autism outreach program including the recruitment of a developmental pediatrician
7	Partnership with Midland College to develop and utilize a multi-disciplinary simulation center for training physicians and allied health professionals throughout RHP
8	Develop a registry database to track care of patients w/chronic diseases such as CHF, COPD, etc. Utilize data to facilitate care of these patients in chronic disease clinics
9	Partner with Texas Oncology to deliver cancer services to the community's uninsured population
10	Expand our partner with patient program beyond focus groups to establish a patient and family member committee to give insight and advise on care programs, etc.
11	Collaborative with MCHS to increase available dental services at clinic locations
12	Invest in care delivery system designed to position one or more employed primary care physicians for certification as a patient-centered medical home.
13	Establish partnerships with post-acute care providers (SNF, Rehab, LTAC, home care) to assure consistency of care delivery throughout the continuum and minimize exacerbation of chronic conditions requiring acute hospitalization.
14	Develop a new mom program incorporating the Texas Ten Step Program promoting breastfeeding as well as educate and encourage TDAP vaccination.
	Medical Center Health System
15	LEAN Implementation to improve operational and financial efficiencies
16	Cancer Navigation Expansion
17	Pediatric Adolescent Community Care- ECISD/MCHS Collaboration
18	"My Story"- Patient Experience/Satisfaction Project
19	Regional Emergency Transportation
20	Cancer Program Expansion- Research Focused
21	Pulmonary Service Line Navigation
	Reeves County Hospital District
22	Chemotherapy Service Line to enable local cancer patients to get their treatments locally
	Odessa Regional Medical Center
23	Establish a primary care patient appointment unit: InQuicker
24	Train number or proportion of providers and staff to appropriately utilize health care interpreters (Via video, phone, or in person)
25	Implement practice management system
26	Develop, implement, and/or enhance a patient experience survey tool

Rest of Addendums are in separate file.